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MIGRANT HEALTH SERVICES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST SESSION

ON

S. 2660

TO EXTEND AND OTHERWISE AMEND CERTAIN EXPIRING PROVISIONS OF THE PUBLIC HEALTH SERVICE ACT FOR MIGRANT HEALTH SERVICES

OCTOBER 21 AND 22, 1969
Washington, D.C.

Printed for the use of the Committee on Labor and Public Welfare

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MIGRANT HEALTH SERVICES

TUESDAY, OCTOBER 21, 1969

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The committee met at 10 a.m., pursuant to call, in room 4232, New Senate Office Building, Senator Ralph W. Yarborough (chairman of the committee) presiding.

Present: Senators Yarborough (presiding), and Dominick.

Committee staff members present: Jack Forsythe, general counsel; James Babin, professional staff member to the subcommittee; and Jay Cutler, minority counsel to the subcommittee.

The CHAIRMAN. The Senate Subcommittee on Health will come to order.

We will open the hearings on S. 2660, the Migrant Health Services, a Public Health Service Act amendment.

The bill was introduced by me with a number of cosponsors from both parties. It is cosponsored also by Senator Javits, the ranking minority member of this committee, and by Senator Prouty, Senator Cranston, Senator Eagleton, Senator Hughes, Senator Kennedy, Senator Mondale, Senator Murphy, Senator Nelson, Senator Pell, Senator Randolph, and Senator Williams of New Jersey. So it is a bipartisan effort with strong support from both parties.

Hundreds of the Nation's communities with an annual influx of migrants still lack an organized program to provide health services to workers and families for the duration of their stay.

Nationwide, the migrant population continues to total approximately 1 million persons, including workers and their families; 900 of the Nation's 3,000 counties are annually temporary homes to numbers ranging from 100 to 40,000 or more.

Every year the migrant health grant funds available are inadequate to respond to the need and requests from communities for grant assistance. As a result, the present program has temporary contact with only about one-third of the Nation's migrants each year.

Contact is made to the extent that the people happen to live or work in the 300 counties which offer personal health care through migrant health projects. Care for migrants in most of the other 600 counties continues to be sporadic and crisis-oriented.

Even for the people with whom the program makes contact, the breadth of services is typically less than adequate. Dental care is often limited or entirely lacking. A sampling of the medical conditions

among patients reported by migrant health projects during the past year was compared with a sampling of medical conditions among patients seen in private physicians' offices during a comparable period (from the National Disease and Therapeutic Index).

Infective and parasitic diseases, diseases of the respiratory system, and digestive system diseases were from two to five times as large a proportion of the total conditions seen among migrants as among the general population.

Among the infective and parasitic diseases, tuberculosis was seen 17 times, venereal disease 18 times, and infestations with worms 35 times as often among migrants as among patients in private physicians' offices.

The need for increased funds is graphically illustrated by comparing statistics that reveal the very low per capita expenditures for health care of migrants, compared with the per capita expenditures for the Nation as a whole.

The average per capita health care expenditure in 1968 for 1 million migrants was about $12, compared with an average per capita health care for the total population of over $200.

Medical and dental services are not the only services that are limited for migrants. Under existing conditions, funds for hospital care are often exhausted by projects before the season is over. Yet project reports show that the use of hospital care by migrants is only about one-fourth that of the general population.

Looking into the future, progress must be made in the coverage of migrants by programs for the general population and improvements in migrants' economic status can be anticipated.

As medicaid and other health programs assume certain costs and responsibilities now assumed by migrant health grants, and as migrants become economically better able to meet their own health needs, the migrant health program may be able to become increasingly a supplement to other programs.

However, for the foreseeable future, the migrant health program must have a separate identity with expanded funds.

While extending this program for 2 years in 1968, the joint conferees from the House of Representatives and the Senate agreed "that this program, because of its importance to the health of the American people, should be considered as a permanent and separately identifiable program, subject to periodic congressional review, and authorization of appropriations."

Notwithstanding the above-stated reasons for continuing and expanding a separate migrant health program, the Public Health Service in late 1968 instituted a reorganization plan that appears to destroy the separate identity and operations of the migrant health program, and obliterate the separate central and regional office staff of the Migrant Health Unit.

It is my belief that this reorganization should be reversed.

Because I believe we need more resources, I introduced S. 2660 on July 18, 1969; it will increase appropriations authorization from the present level of $15 million in fiscal 1970 to $40 million in fiscal 1975.

It is my earnest hope, that by 1975 a $40 million annual appropria-

tion specifically for migrant health care—coupled with the resources of other programs and of migrants, themselves—will bring the Nation's migrant families to a health care level equal to that of the general population.

You may wonder how that can be when the general population spends $200 a year and with the migrants it is only $14 per person.

This $40 million for 1 million migrants would bring that to $40 a year. We have stated that we are hopeful that by 1975 they will be able to use resources of other programs.

I pledge to fight for full funding of the migrant health program for 1970 in the Senate. The administration is also requesting the full authorization in this very worthwhile program. I will also fight for increased funds for the future as authorized by my bill, S. 2660.

We all know it is not easy to get money appropriated for constructive things. The big money goes for destructive things.

Hopefully, as Abraham Lincoln says, the better natures of mankind will shine through and we will begin to spend as much money for constructive purposes for the human race as we spend in trying to destroy it.

I order printed in the record the text of S. 2660 in its entirety.

(The bill referred to follows on p. 4.)

91st CONGRESS
1st Session

S. 2660

IN THE SENATE OF THE UNITED STATES

July 18, 1969

Mr. Yarborough (for himself, Mr. Cranston, Mr. Eagleton, Mr. Hughes, Mr. Javits, Mr. Kennedy, Mr. Mondale, Mr. Murphy, Mr. Nelson, Mr. Pell, Mr. Prouty, Mr. Randolph, and Mr. Williams of New Jersey) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

---

A BILL

To extend and otherwise amend certain expiring provisions of the Public Health Service Act for migrant health services.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That section 310 of the Public Health Service Act is
4 amended by striking out "$9,000,000 each for the fiscal year
5 ending June 30, 1968, and the next fiscal year, and $15,-
6 000,000 for the fiscal year ending June 30, 1970", and
7 inserting in lieu thereof "not to exceed $15,000,000 for the
8 fiscal year ending June 30, 1970, $20,000,000 for the fiscal
9 year ending June 30, 1971, $25,000,000 for the fiscal year

1 ending June 30, 1972, $30,000,000 for the fiscal year end-
2 ing June 30, 1973, $35,000,000 for the fiscal year ending
3 June 30, 1974, and $40,000,000 for the fiscal year ending
4 June 30, 1975".

The CHAIRMAN. Senator Dominick.

Senator DOMINICK. In my own State of Colorado, there were 19,370 migrant workers located in 26 counties having 100 or more seasonal or agricultural workers and nonworking family dependents that either migrated into or resided in the area, at some point during 1967–68.

At a Federal level, the amount spent per migrant in migrant health project areas totaled about $12 last year including funds from other sources, compared with a national per capita health expenditure of about $250.

The magnitude of the need to improve health care—services, resources, and facilities—for migrant agricultural workers and their families, continues to expand and I am pleased the Health Subcommittee has scheduled these timely legislative hearings.

Whether we report out S. 2660, the chairman's bill providing a 5-year extension of grant authorizations at increased annual $5 million increments, or the House bill introduced by Mr. Rogers, or incorporate the administration's position—to be set forth by Dr. Egeberg before this committee—will depend upon the testimony adduced to this hearing.

All of these actions reflect Federal responsibility to assure the success of the Nation's commitment to raise migrant health standards.

We have made great progress in upgrading the health services and conditions of migrants and their families since the Migrant Health Act was enacted into law in 1962.

We have made great strides forward:

In overcoming lack of knowledge on the part of the migrants themselves and on the part of communities and health personnel about the problems related to migrant health and health care;

In expansion and decentralization of health services to more effectively serve the migrants and their families;

In the development of new sources of personnel to supplement available professional health services; and

In the establishment of health care services in each migrant-impacted community and then meaningfully linking the services of these communities to provide a continuum of health services.

It is my hope we will be able at these hearings to review the accomplishments and improvements being made to determine how we most effectively should go about expanding public services authorized under the Migrant Health Act, and provide the migrant workers and their families the opportunity for access to needed health services.

Before closing, I would like to commend President Nixon for the interest this administration has shown in the migrant health program.

His budget request of $15 million is an increase over the Johnson budget for fiscal year 1970, and will fully fund the $15 million permitted under existing law.

I would like to place in the record at this point a comparison of these budget figures.

MIGRANT HEALTH PROGRAM

SEC. 310 PUBLIC HEALTH SERVICE ACT

[1970 budget in thousands]

1969 estimated expenditure	$8, 100
1970 authorization	15, 000
1970 Johnson budget	12, 910
1970 Nixon budget	15, 000

The CHAIRMAN. Thank you, Senator Dominick.

The first witness this morning is Dr. Roger Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare.

We welcome you back, Dr. Egeberg. I believe you are accompanied by a staff that has special expertise in this field. Please come forward.

STATEMENT OF DR. ROGER EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY MISS HELEN L. JOHNSTON, ACTING COORDINATOR FOR MIGRANT AND RURAL HEALTH, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; DR. JOHN CASHMAN, DIRECTOR, COMMUNITY HEALTH SERVICE, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; AND DR. JAMES CAVANAUGH, DEPUTY ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS

Dr. EGEBERG. For the benefit of those present, on my left is Miss Helen Johnston, Acting Coordinator for Migrant and Rural Health.

On my right is Dr. John Cashman, Director of the Community Health Service, Health Services and Mental Health Administration; and beyond him is Dr. James Cavanaugh, who is Deputy Assistant Secretary for Health and Scientific Affairs.

I would first like to express my gratitude for your strong stand and I appreciate having heard the statement you just made.

In reviewing the problem, I hope I don't duplicate anything you have said. If so, I will skip it.

The CHAIRMAN. Your entire statement will be in the record, Dr. Egeberg. If I have said something that is in yours, what I have said as a layman and you are bringing all of your expertise for many years, not merely as a medical doctor but also an administrator and educator.

You may proceed.

Dr. EGEBERG. Thank you, Mr. Chairman.

I am happy to appear before you today concerning legislation to extend the expiring authorization for project grants to improve health services for migrant agricultural workers and their families.

The bill under consideration today—S. 2660, introduced by you, Mr. Chairman, and other members of the subcommittee—would extend for 5 years the grant authorizations in section 310 of the Public Health Service Act.

For these 5 additional years the bill would authorize appropriations of $20 million for fiscal year 1971, $25 million for 1972, $30 million for 1973, $35 million for 1974, and $40 million for 1975.

BACKGROUND AND NEED

Migrant farmworkers and families present a unique problem in the planning and delivery of health care. They are unequally distributed over the Nation's States and counties. They reside in particular places for only brief periods each year. In each place they are strangers.

Many—although they have been American citizens for a generation or two—still speak Spanish more easily than English. Some speak no English at all.

Wide dispersion in isolated areas, lack of familiarity with their temporary communities, fear of community hostility, unfamiliarity with modern health concepts and practices, voicelessness in community planning—all conspire to make migrants forgotten citizens when it comes to local provision of health and other services.

Even when States and localities recognize their needs and try to plan for them, great difficulties are encountered. They are "here today and gone tomorrow," gone to some destination which is perhaps unknown even to themselves.

Over the years, some migrants have left migratory work in agriculture, displaced by machines that quickly and easily performed the work of hundreds of human hands and backs.

But the need for a mobile supply of farmworkers to meet the peak labor demands of hundreds of the Nation's agricultural counties continues. Only with a mobile labor supply can the American appetite be satisfied for fresh fruits and vegetables that do not yet lend themselves to machine harvesting.

The total number of migrant farm workers and dependents appears likely to continue around 1 million, fluctuating annually according to weather, crop, and market conditions.

The best clues to the health problems of the migrant population come from the counties the people consider "home." Here 18 percent of the babies are delivered by midwives and the infant mortality rate is conservatively estimated at one-fourth higher than the national average.

Parasitic infestations and tuberculosis—conditions associated with poverty, poor nutrition, and poor environment—are common.

Iron deficiency anemia is prevalent, and nutritionally based diseases such as beriberi, pellagra, scurvy, and rickets are occasionally found. Dental decay is almost universal.

Yet the counties where the problems are most severe are seriously handicapped by shortages of health manpower to deal with them. The ratios of physicians and dentists to the population of these counties are less than half the national average, even without the migrant.

The counties as a whole have median family incomes averaging about three-fourths of the national median.

ACCOMPLISHMENTS UNDER THE MIGRANT HEALTH ACT

The Migrant Health Act was devised to make health care accessible to migrants through helping States and communities adapt their health care system to the migrant's unique situation and need.

In striking contrast to the half dozen isolated community efforts of 6 years ago, 118 single or multicounty grant-assisted projects are serving migrants in 35 States and Puerto Rico at the present time.

The projects provide medical, dental, and related health care in places and under conditions which make the services easily accessible.

A typical project operates one or more family health service clinics during the season or year round. Projects in northern work areas usually operate only for the duration of migrants' employment in the area. Those in home-base communities usually operate year round since migrants move in and out throughout the year.

The clinics are open at least once or twice weekly, usually during the evening, so that workers as well as family dependents can obtain remedial and preventive health care.

Some projects have mobile medical units, but most operate their clinics in churches, school buildings, labor camp units or other temporary facilities near the places where the people live.

One or more physicians, nurses, technicians and aides travel from 10 to 50 or more miles for each evening's work in these clinics.

Clinic physicians treat all family members for whatever illnesses, injuries, or other needs they present, referring patients for further special tests or treatment if necessary.

Immunizations, family planning services, and nutrition counseling are equally as important as the treatment provided. Typically, the clinics are supplemented by arrangements with local physicians or hospital outpatient departments to provide emergency care between clinic sessions.

The medical services are supported by an active outreach through nurses and aides who visit migrants in their homes for early case finding, health counseling, necessary referral, and posttreatment followup. Support is also received from sanitarians concerned with the removal of health hazards at the home and work sites.

Projects encourage the participation of migrant families in planning for services to meet their expressed needs and desires. Many staff members consider each contact with a migrant as an opportunity for health counseling.

Some projects conduct systematic health education programs on a group basis to encourage good homemaking and safety practices, and to develop better understanding of health services and their use.

Nearly 1,000 physicians are now serving migrants through 225 family health service clinics supplemented by care in their own offices or in hospitals. An estimated 325,000 migrants lived in counties served by projects for at least part of the 12 months' period ending last June 30.

During the year they made 210,000 medical visits and 28,000 dental visits to project facilities.

In addition, nurses and nurse aides made 160,000 casefinding and health counseling visits to labor camps, other migrant homesites, schools, and day care centers.

I would like to stress the importance of the casefinding and the health counseling that goes on on this basis.

Many labor camps now have safe water supplies, improved toilet facilities, and more adequate shelters as the result of more than 100,000 field inspections and follow-up visits made by sanitarians and sanitation aides last year.

Funds for hospitalization under the auspices of migrant health projects became available for the first time in 1967. Currently about half the projects provide hospital care in addition to other services under the provisions of the 1965 and 1968 extensions of the Migrant Health Act. Last year, 3,600 migrants were hospitalized under project auspices.

Many communities and individuals have invested their own time, facilities, equipment, funds, and other items essential to the provision of project services.

Project staff members are constantly working with growers, hospital administrators, medical societies, civic organizations, and other public and private groups toward this end.

An average of 40 percent of project support—in cash and in kind—has come from other than migrant health grant sources.

Within the last month, with assistance from the Public Health Service staff, the national organization of more than 400 orders of Catholic Sisters in the United States has adopted a nationwide plan for involvement of their trained teachers, nurses, and social workers in services to migrants.

The Sisters will volunteer their services through existing projects and will help to organize services where they are deficient.

They will be a much needed source of additional professional manpower in rural areas where an influx of migrants creates an almost overwhelming problem.

CONTINUING NEEDS

In spite of the progress made, two-thirds of the Nation's 900 counties where migrants live temporarily still have no grant-assisted services. The services of existing projects are heavily utilized, yet they are far from adequate.

On the average each migrant experiences one-fourth as many medical visits and one-twentieth as many dental visits annually as the average person in the United States.

Health expenditures per migrant in project areas totaled about $12 last year, including funds from all sources, compared with a national per capita health expenditure of about $250.

The CHAIRMAN. I will amend my statement from $200 to $250. I believe yours is more accurate.

Dr. EGEBERG. I was going to call it an average of $225. If you trust my staff, we will call it $250.

The CHAIRMAN. I will accept $250.

Dr. EGEBERG. Thank you, sir.

Some of the specific improvements needed include:

1. Additional family health service centers established in or near large migrant labor camps or other points of migrant labor concentration.

2. Improvement of the quantity and the comprehensiveness of dental as well as medical services for all family members.

3. Increased "outreach" services through nurses and aides for casefinding and health counseling.

4. Increased assistance by professional health educators to strengthen the health education component of migrant health services.

5. Intensified sanitation services to improve migrants' living and working environment.

6. Addition of medical social service, nutrition counseling, and homemaker services.

7. Recruitment from among migrants and ex-migrants of greatly increased numbers of aides to help relieve professional health manpower shortages and to establish more effective liaison working relationships with migrants.

8. Improved arrangements for hospitalization including post-hospital followup and services.

Before commenting upon the provisions of the legislation under consideration by this committee, Mr. Chairman, I wish to express my own deep concern and that of this administration with the health problems of the migrant and his family.

The administration considers this a high priority program and this year is asking full authorization of $15 millon for funding programs of health assstance to migrant workers and their families.

The House has reduced this request back to the 1969 level of $8.1 million, and the administration is appealing this before the Senate.

As further evidence of our commitment to the task of improving the health of these people, we are currently considering a number of program alternatives which will increase the effectiveness of our efforts to solve the migrants' unique health care problems.

As you know, Mr. Chairman, Secretary Finch has appointed a blue ribbon task force to review the medicaid program in its entirety.

This group is currently considering our entire commitment to the migrant worker, and is investigating the possibility of including such persons wthin the scope of medicaid benefits.

Also under consideration is a proposal which would consolidate the migrant health activities of DHEW with the partnership for health program.

This proposal would provide for the setting aside of funds under section 314(e) of the Public Health Services Act specifically for migrant health projects.

This would be consistent with our desire to consolidate and simplify the present proliferation of grant authorities, yet give the special attention to migrant health that is required.

Furthermore, the President's proposed family assistance plan, when enacted into law, will have an impact on the health of migrant workers by increasing the income of migrants, thereby ameliorating that part of the unique health problems caused by lack of money.

Therefore, in view of these new program needs and directions, Mr. Chairman, we support the extension of the existing grant legislation; however, we would like to recommend that the extension be for 2 years rather than for five, as provided in S. 2660.

We anticipate that viable alternatives will become evident, and would be appropriate for congressional review within that time.

As for the proposed increases in the annual appropriation authorizations, in the light of prevailing budgetary and expenditure constraints

and uncertainties, we recommend that the specific annual authorizations be replaced with an indefinite authorization—that is, "such sums as may be necessary."

However, in a recent letter to the Health Subcommittee in the House of Representatives, we advised that we would go along with your suggestion of $20 million next year and $25 million the following year.

This concludes my formal statement, Mr. Chairman, but my associates and I would be happy to answer any questions your committee might have in mind.

The CHAIRMAN. Have you a copy of that letter you referred to, Doctor?

Mr. CAVANAUGH. We will supply that for the record, Mr. Chairman.

The CHAIRMAN. All right.

(The letter referred to follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
HEALTH AND SCIENTIFIC AFFAIRS,
Washington, D.C., October 9, 1969.

Hon. JOHN JARMAN,
Chairman, Subcommittee on Health, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: It was a pleasure to appear before your subcommittee on Monday, September 29, 1969, to testify on H.R. 13432 which extends and amends certain provisions of section 310 of the Public Health Service Act.

During the hearing we were asked for our suggestions with respect to (1) a more limited extension of eligibility for services than is in the bill and (2) specific dollar appropriations limitations—assuming the Committee wishes to amend the existing program in this way. Our suggestions are as follows:

1. With respect to the extended eligibility language ("and other seasonal agricultural workers")—while we are not prepared to offer specific language, we would suggest inclusion, instead of this provision of the bill, of an amendment to section 310 of the Public Health Service Act authorizing the Secretary, in accordance with regulations, to permit the use of grant funds appropriated pursuant to this section to provide health services to persons, other than the migrant workers and their families now covered, when he finds that the provision of such services will contribute to improvement of the health conditions of migrant workers and their families.

2. Possible dollar limitations (subject, of course, to the current fiscal situation) on appropriations authorizations: 1971—$20 million; 1972—$25 million.

I hope these suggestions will be helpful to your Committee.

Sincerely,

ROGER O. EGEBERG, M.D.,
Assistant Secretary.

The CHAIRMAN. Your recommendation is "such sums as may be necessary." It strikes me as a very fine recommendation. I would anticipate that would have some difficulty with some members of the committee. That is what they call an open end authorization.

I agree with your recommendation but I feel it would have great difficulty getting passed.

Dr. Egeberg, I do seriously question, very seriously, your recommendation that this be for only 2 years.

Our experience is that we have great difficulty getting these appropriations bills passed by the end of the fiscal year.

In this bill there is $15 million for the fiscal year ending June 30, 1970. We are in that fiscal year now. Doubtless, on whatever appropriation bill passes, the two Houses will go into conference.

Suppose the Senate put in $15 million and we would go to conference. The House Members would say, "Look, it is already November,

and this started July 1, so half of this year is gone, or almost half of the year is gone."

By this long delay, there is method in this madness, despite what you read in the papers. It is not all laziness in the Congress.

People do not want this amount of money for many of these programs appropriated.

We are always met with the plea that this is not the party but it is the personality of the particular person voting.

Then they say, "This year is half gone. You couldn't spend that if we appropriate it."

If we have continuity, so we can see ahead and know that this is to be escalated upward to try to meet some of these great needs, then we have a better opportunity of getting the kind of moneys you want to put into this program.

If we authorize it for only 2 years, that takes us to June 30, 1972. Then we would be up against it next year getting another renewal, from the time we started on the bill until the program expired on June 30, 1972.

We had a recommendation yesterday from the administration to have an extension for 1 year instead of 5 years. That means this committee sits here twiddling its thumbs for 1-year extensions.

You cannot appropriate money until there has been an authorization. If you have to wait each year to get an authorization and then appropriate money, we just meet with disaster. We have had professionals tell us unless there is some continuity offered, unless there is hope for the future, unless they can see down the road some continuity, men or women just do not want to go into the programs. They don't want to go on something that will expire in a year.

With all due respect, Dr. Egeberg, if we limit this to 2 years, our past experience—that is unless we have an authorization, unless the people who you are trying to get into the program see some hope down the road for some continuity of effort in that field, it is more difficult to get personnel, in a field where the personnel shortage is as drastic as it is in the health field.

Let us get some of these other programs out of the way so we can move forward to other programs, or at least authorizations.

The Bureau of the Budget then can look ahead to future years, and so can the Congress.

I feel, based on my 11½ years on this Health Subcommittee under the leadership of the great Lister Hill, and you know the great things he has done for medicine through law in this country, I feel that the 2-year extension would be very unwise. It should be 5 years for proper planning ahead and for the Congress to plan ahead.

We have met this in the health field and in the education field. Health administrators and education administrators say if we cannot see some hope for planning down the road, it is disastrous to us in planning our budgets in the State, college or school district levels.

I hope you can see the merit in our recommendation. I will continue to press for the 5 years, not that I don't highly value your recommendations, but I feel that after 11½ years, I know about the difficulty in appropriating; therefore the 5-year authorization should be had.

On your last page, I am concerned with the possibility of losing the identity of migrant health programs by the bloc grant approach.

I hope you will keep the committee informed of the reorganization plan you referred to on page 8. Does that contemplate a bloc grant to the States, that reorganization plan?

Dr. EGEBERG. It definitely contemplates keeping the identity of the migrant health program, its financial identity, and so forth, within a structure of two other programs, the Appalachian program and 314(e).

I feel that a new program is in need of real identity until it is strong enough and broad enough to stand being absorbed, until it is sure enough of its money so that absorption won't mean that it is just going to have to get the money from the other program. We are very mindful of this.

Dr. Cashman is very mindful of this. Perhaps I could ask Dr. Cashman to say a few words.

Dr. CASHMAN. As I understand your question, Senator, relating to Dr. Egeberg's prepared statement, you asked about whether or not that part of the partnership was the bloc grant.

What Dr. Egeberg is referring to is section 314(e) of the Public Health Service Act, a project grant authority. Under the project grant, one is certainly able to earmark and identify portions of a program for which one may spend money.

For example, this year, the work with German measles immunization is under this particular authority and moneys have been set aside for that program.

If your question relates purely to organization, that is another question I would be glad to speak to that.

The CHAIRMAN. That is what I am interested in.

Does that mean a separate program in HEW or would this be absorbed into another program and they would be all in one program?

Dr. CASHMAN. I think that one organizes to get the multitude of programs for which he is responsible accomplished.

While there may not be a division or branch called migrant health, we do have an identifiable migrant health program carrying out the wishes of Congress in a grant program dealing with project grantees and a constituency in order to promote the goals of the migrant health program.

One can certainly carry out identifiable programs without having in a little pigeon hole several people who do only those things.

In the Community Health Service, I won't try to recall all of the types of programs for which I am accountable. If you recall, you were very kind to host a film for us one day on "Information and Referral." That is an item of our concern, but I don't have a specific two, three, or half dozen people who only do information and referral.

Our responsibilities range all the way from drafting standards for the medicare program to helping the States improve their licensing programs for hospitals and nursing homes, the promotion of home health services, the promotion of statewide comprehensive health planning, areawide comprehensive health planning, the administration of a grant program for the Appalachian Regional Commission, all of the partnership for health legislation, the promotion of group practice, prepayment, and so forth. All of these are medical care-related activities, Senator.

You spoke awhile ago about the great paucity of health personnel, people who are facile with medical care administration, people who

are concerned, or have an interest, and experience, in financing of health care and so on.

There wouldn't be enough people with those kinds of expertise to place them in every single responsibility that we have.

However, migrant health has a high priority in the Community Health Service and we feel that we are organized, both centrally and through our regional structures, to provide the kind of expertise to migrant health grantees to help to improve the health of the migrant.

The CHAIRMAN. I have grave doubts about this consolidation of the migrant health programs with other programs if you don't have someone responsible for migrant health specifically. I feel this program might lose its drive.

Dr. CASHMAN. We are not consolidating, Senator, this program with other programs. It is just that organizationally we would place programs that have commonalities.

The CHAIRMAN. I am not arguing about where you put the desks in the offices.

Dr. CASHMAN. I am glad to hear you say that.

The CHAIRMAN. What I am concerned about is whether it is scrambled together and loses its identity. If it does, I feel it will lose its drive.

I feel that on a program to consolidate, when there are men at the bottom of the totem pole and you rescramble, they get lost again.

The words of the Bible come through too often. To him who has shall be given, and to him who has not, verily, I say even that little will be taken away.

Dr. CAVANAUGH. Senator, I wonder if I might comment on that.

We have no plans at this time to merge the grant authorization or appropriation under this program with bloc grants under the partnership for health, section 314(d).

The CHAIRMAN. That is the concern I had about a part of your statement. Dr. Egeberg talked about the partnership for health.

Dr. CAVANAUGH. That was the project grant 314(e). We are using that as one alternative. But that would not take place for at least 2 years.

The CHAIRMAN. That is the reason I want this for 5 years. I want to try to stave it off for five until we get better health.

Dr. Egeberg, suppose the people were callous enough not to really care about these migrant workers unless it was dangerous to them.

Is it safe for the population that has $250 a year spent on them and do see doctors and have hospitalization available, is it safe for them to eat the fruits and vegetables piked by these people with such a high incidence of disease among themselves and their families?

Are they endangering their own health by letting people in the community pick their fruits?

Dr. EGEBERG. Some of the sanitation arrangements I have seen in fields where there are leaf crops would make me want to boil my salads.

The CHAIRMAN. I think that pertinent statement answers the question.

So there is a safety factor to the general health, not alone to the migrant workers. This is absolutely essential for the migrant workers and others as well.

Dr. EGEBERG. I think this is an important extension.

The CHAIRMAN. How many of the local areas in the country now, Dr. Egeberg, are receiving special project grant funds under the partnership for health program?

Dr. CASHMAN. What was the question again, Senator?

The CHAIRMAN. How many local areas are currently receiving special project grant funds under the partnership for health program?

Dr. CASHMAN. We had about 750 projects this past year. Last year it was in the neighborhood of 800. Of course, the 314(e) project grant authority, Senator, as you will recall, was the bringing together of seven project grants that existed previously; cancer, venereal disease, tuberculosis, mental retardation, neurological and sensory, radiological health, and community health.

The CHAIRMAN. How many of those grants are for migrants?

Dr. CASHMAN. We don't have any of those grants that are for migrants.

We are interested in trying to use the 314(e) mechanism to try to improve the health of the rural, nonmigrant people.

In many parts of our country, the migrant health program is really the only medical program that exists in that particular area. We would like to build around our migrant health program.

We can use the 314(e) mechanism to improve the health services for the nonmigratory people in those areas. We would propose to do this. This would be an economical use of the funds. But we don't have any 314(e) grants for only migrants.

The CHAIRMAN. Suppose, then, the data I have was erroneous. It is really more favorable to the partnership for health than yours.

Where you say none, I have been advised there was one program.

Dr. CASHMAN. The one you are speaking of is a combination, combining services for migrants under a migrant health grant with services for rural nonmigrants under 314(e).

Dr. CAVANAUGH. Senator, I would just like to see the direction that we are headed here. I would point out that we have chosen as the primary vehicle for solving the migrant health problem of this Nation today the very act that we are here to talk about this morning.

I think the evidence of that is that we have asked for amendments to the 1970 budget to increase the amount requested to $15 million under this program.

As you will recall, the earlier budget requested somewhere in the neighborhood of $12.9 million. We made a very extensive review of that budget in January, February and early March, and decided that a key priority area was migrant health, and, as a result, came to the Congress with a request for full funding. That is a $15 million request, above and beyond the $12.9 million requested by the previous administration.

The CHAIRMAN. I want to congratulate the administration and congratulate you in this field for that increase in that budget request.

It is very difficult to get any kind of an increase in the April budget. I highly commend you for this.

I am hopeful that the Senate will do better with this than the House did. I believe the House appropriation was $8 million and you requested $15 million. I think you should have full funding. I hope that will occur in the Senate Appropriations Committee.

Miss Johnston, I believe you are in charge of Migrant and Rural Health Services, Health Services and Mental Health Administration?

Miss JOHNSTON. I am the Acting Coordinator for Migrant and Rural Health in the Division of Health Care Services.

The CHAIRMAN. What was the size of your staff before the reorganization? Specifically, what was the size of your staff for Migrant Health? How many people did you have specifically for Migrant Health before the reorganization?

Miss JOHNSTON. We have about 20 or 22 professional staff members, supported by clerks and by secretaries. These professional staff members were deployed through the nine regional offices as well as in the central office of the Public Health Service.

The CHAIRMAN. How many do you have at this time?

Miss JOHNSTON. Actually, theoretically, the Division resources are available to work on Migrant Health, as on Comprehensive Health 314(e) and on Appalachian Health.

My own staff consists of one person new in the Government who is temporarily substituting until I can get a secretary.

The CHAIRMAN. You mentioned 22 professionals with supporting clerical help. How many did you say you have now specifically assigned to Migrant Health?

Miss JOHNSTON. Specifically assigned to work with me is one person.

The CHAIRMAN. You formerly had 22?

Miss JOHNSTON. About 22 professionals. This was a multidisciplinary staff, including a physician—actually, we had three physicians working with us about 2 years ago. Two were in the field and one in the central office.

We had a public health nurse, two health educators, a hospital administrator, a couple of people who were specifically working on the grants administration, and possibly a couple of others.

We worked as a multidisciplinary staff to try to approach together the planning and program development for migrant health.

The staff developed a great deal of expertise in working with rural communities. The original thought was that we needed to have this expertise to help the rural area compete with the urban area.

The urban areas, or at least most urban areas, have a good deal of professional health organizational and administrative expertise. They can develop applications for grants. They can find out about grant resources that are available to them.

When it comes to the rural areas, such areas as migrants most frequently live in, the amount of expertise is very small.

What we were trying to do was help them compete with the better supplied areas.

The CHAIRMAN. Do you feel that this multidisciplinary approach works best for the migrants?

Miss JOHNSTON. I would say that certainly in the past year we have not been able to get the organized drive to work with local communities in migrant impacted areas that we had before.

The CHAIRMAN. You mean you haven't been able to get that since you adopted the new organizational approach?

Miss JOHNSTON. That is right. This took place about the first of January. I do think that in any transition from one type of organiza-

tion to another you are bound to have problems. I think that after about 9 months we ought to expect some of these problems to start to be worked out. I think the problems are still there.

The CHAIRMAN. When you cut 22 professionals in the field of migrant health down to one, how will the problem work itself out? You won't have anybody working on it. There won't be anybody there to work on it.

Miss JOHNSTON. You can't say that nobody is working on it. But there is a new system of priorities, and migrants are fitted in with comprehensive "E" priorities, Appalachian health priorities, neighborhood health centers and so forth.

The CHAIRMAN. Dr. Egeberg, while we are here, I want to say I am greatly disturbed about what is happening to public health in this country over the past months. There has been no Surgeon General appointed yet. Is the Office of Surgeon General appointed yet. Is the Office of Surgeon General filled yet?

Dr. EGEBERG. No; it is not filled. It should be soon.

The CHAIRMAN. How long has it been vacant? Months and months?

Dr. EGEBERG. About 2½ months.

The CHAIRMAN. And the Public Health hospitals serving primarily seamen, which are available for wide research that private hospitals cannot engage in, there are only two out of eight left.

As chairman of the Appropriations Committee which deals with the Bureau of the Budget, I have asked some questions about that this year, and will ask more next year.

What I have been able to learn as chairman of this Health Subcommittee is that this whittling away at the Public Health Service of the country comes through the Bureau of the Budget, and they whittle constantly at it.

They are trying to close the two hospitals at Lexington and Fort Worth, the only two in the country supported by the Federal Government, both founded in the 1930's, to engage in research and treatment of narcotic addiction.

We see that constant drive to close up the Public Health Service of the United States. I want to find out where it is coming from. I don't believe it is coming from your department.

Senator DOMINICK. Isn't it true the administration was talking about closing Fort Worth but expanding Lexington?

The CHAIRMAN. I never heard of that.

Senator DOMINICK. This was the proposal brought by the administration.

The CHAIRMAN. They were going to close Fort Worth one year and Lexington the next. They said they would hold Lexington open 1 more year.

Dr. EGEBERG. I can assure you I am looking into the whole question of Public Health Service hospitals. My own prejudices are that there is a need for some of the things that they can do, that they have been doing, and that they could do in the future.

I believe you expressed it very well one day here.

The CHAIRMAN. I am not holding you responsible. I think this drive started on 23 Public Health Services in 1946 and there has been an insidious drive to close these up over the decades, regardless of the administration or party in power.

As far as I am able to find out, it comes from inside the Bureau of the Budget. I am advised they don't have a single health professional in that office.

Dr. EGEBERG. I think many years ago those that were closed were closed at the urging of the Department of Health, Education, and Welfare.

The CHAIRMAN. I am giving you a cleaner bill of health than you are entitled to, then.

Dr. EGEBERG. Thank you, sir.

The CHAIRMAN. I am not speaking of you personally. I am speaking over the decades.

Isn't it true, Dr. Egeberg, that migrants have special health problems? Their health problems are different from the average of the sedentary population, from the way they live?

Dr. EGEBERG. Yes; I think they have special health problems, as indicated by the high incidence of tuberculosis, the high incidence of parasitic infestations, and certainly when it comes to certain of the fungus diseases, their closeness to the soil in certain areas makes them much more apt to get that.

They also have the psychological disadvantage of always feeling they don't quite belong.

The CHAIRMAN. And the community helping them feels that way.

Dr. EGEBERG. Yes; I would say as I have traveled around that it is difficult for a community not to help them feel that way. The community also feels a bit threatened by transients, as they feel migrants are.

It is true the community does help the migrants in many, many instances to feel that they are a part of it. I think everybody is working on this.

But their sanitation problems, their living problems, while many of these are improved and many growers are forward-looking and are furnishing good houses, if a grower has somebody occupying a house for about 2 months a year or 6 weeks a year you can see why he doesn't make it the best house on his place.

Miss JOHNSTON. I think one unique feature of the migrant situation is the fact that his health problems cannot be solved in a single community. Several years ago the Commission on Health Care invented the term "problem shed." What they were talking about was, as they call it, the "community of solution" for a health problem.

The problem shed for a migrant extends, in the case of your own State, from Texas to the Puget Sound area, from Texas to New England. You have to have the interlocking services of a number of different communities in order to provide migrants the same kind of access to health services that the rest of us expect.

One of the things that the staff of the migrant health program did in the past, working with local projects, was to try to work out mechanisms to have this constant communication process taking place among different communities so that migrants had access and had continuity of care as they moved from one place to another.

I think you will be interested in seeing a report that was recently developed in the State of Texas. Mrs. Pat Alex, on the Texas migrant health program staff, has accumulated all the referrals that Texas received from other States, and I believe the number went up to several hundred a day from all the States of the northern areas where migrants from Texas are employed.

She tried to find out what percentage of these had actually resulted in a contact in Texas with a professional health worker so that the people got continuity of care.

Unfortunately, I haven't had time to read her report in detail yet. It is quite a fat report. But apparently they have had considerable success in locating the people when they come back to Texas and providing them whatever further treatment was necessary to follow up on what had been done in the northern areas.

The CHAIRMAN. I am very much interested in that report. I do not have a copy. Has it been printed or mimeographed? Is it available in some form?

Miss JOHNSTON. It has been printed. Dr. Peavy may have a copy of it.

The CHAIRMAN. He will be the next witness and we will ask him about it. The migrant farmworkers that go out from Texas, many of them from the Rio Grande Valley, the southern edge, end up on the Canadian border, or in northern Montana.

You have mentioned New England, where they go to work on the potato crops. I missed the one about Puget Sound. They pick berries in Washington State, I believe.

Let me ask one other question. Due to these special health problems, doesn't that require a specific staff with special or specific expertise to deal with this problem?

Miss JOHNSTON. I think if you have a problem and you recognize it as an acute problem, the best way to deal with it is to have a staff that focuses on that problem.

I think this has been identified to some extent in another agency of government, in the OEO, in the neighborhood health centers for the ghetto residents.

I think as long as the ghetto residents are as far behind the rest of the Nation as they seem to be in their access to health care, you need to have people who devote their time to organize a system of health care that will bring them up to the rest of the population. I think the migrants are a very comparable group.

The CHAIRMAN. I know professional men in Texas of Mexican-American extraction who traveled with their parents for years in trucks as migrant workers in the fields across the country and all the way to the north to the States touching the Canadian border.

In some way they were able to break out of that pattern. The family made a great effort. Perhaps they were in the service and got further education under the GI bill. As professional men, however, they know what it is to live in these camps and they know the absence of medical facilities, toilet facilities, and how bad the living conditions are.

If we just take the facts you have stated, they would negate the case for the reorganization of this Migrant Health Division and the fitting it in with the general partnership for health, would it not?

From the facts you have stated, it would seem to me to disprove the validity or suggestion that all this be combined in one big office.

Miss JOHNSTON. I think you can keep the focus on migrant health and still use the resources of other governmental programs in the migrant impacted areas. I think this needs to be done.

It has been one of the objectives of the migrant health program from the very beginning, to make the fullest possible use of available resources, not only the resources of the partnership for health, but the resources of medicaid to the extent they are available, the resources

of children's bureau programs, such as the maternal and infant care program, and the resources of volunteer agencies.

The CHAIRMAN. Is as much being done for the migrants today through your office as was being done a year ago today through that office?

Miss JOHNSTON. If you are thinking about the grant operations, there are as many project grants now as there were a year ago.

The CHAIRMAN. I am talking about direction from your office to see that it is properly done.

Miss JOHNSTON. The reorganization has changed the administrative pattern for direction of the program. I am no longer the chief of the program.

The CHAIRMAN. You do not have supervisory power. Where is that supervisory power exercised now, if at all?

Dr. CAVANAUGH. It is in Dr. Cashman's office, Senator. He is Director of the Community Health Services within the Health Services and Mental Health Administration.

That program has responsibility for a whole host of related health services activities, including the migrant health program.

The CHAIRMAN. It is one of the community health service programs?

Dr. CAVANAUGH. That is correct. It is an identifiable component, identifiable in terms of Miss Johnston being identified as coordinator of the migrant and rural health services, and identifiable through the appropriation and authorization process as well.

The CHAIRMAN. Doesn't the community health program carry with it a connotation of care in one area, whereas migrant health care is something mobile, here today and gone tomorrow, as has been described here? They stay such a short length of time that people don't get the feeling of being part of the community.

Dr. CASHMAN. I don't think that an organization's name always describes itself completely to all people.

In some instances, a community can be a State or a small community or an area.

I would like to correct what I thought I heard. There is a very strong professional effort and a multidisciplinary concern for the migrant health program. It has not lost its identity.

As Dr. Cavanaugh pointed out, we have been able to come forward this year for a singular increase which shows our intent.

I pledge to you that we are using every resource at our disposal to carry out the migrant health program.

It is just that one organizes to get one's work done—I think all good men can sometimes disagree on precise organization.

We are hampered by the lack of medical care administrators, health care administrators, public health nurses, physicians, dentists, and pharmacists, people who have knowledge about the use of such professional manpower.

We are using what we have to our best advantage. It is my impression that we are not causing the program embarrassment by the present organization.

The CHAIRMAN. My concern is further highlighted by the knowledge, having been on this Health Subcommittee for 11½ years, of what was happening to the handicapped. The handicapped were not getting much attention until we set up the Bureau of the Handicapped in the educational field.

About 5 million of the 50-odd million schoolchildren in America, according to the best estimates we could get, were physically or mentally handicapped. It took more money and special training for them. They were not getting that.

We set up a Bureau for the handicapped and put money into it. They are getting better education and better training. Of course, that touches on the field of medicine, too. But they were not getting anything.

We passed the Elementary and Secondary Education Act and put vast sums of money into that for the economically disadvantaged.

We estimated they numbered about 8 million. At that time, we had about 5 million handicapped and nothing was being done for them, other than conventional teaching in a room where they were pushed over to the side because with the handicap they didn't fit into the pattern of the conventional classroom.

We found it necessary to set up specific programs, to see people who had problems separate from the majority of the people in the community did get the attention necessary to give them an opportunity in life.

I mention that as one other item.

Dr. CAVANAUGH. Senator, I would like to stress again this administration's commitment to the migrant health program.

I would point out that since the reorganization occurred, two fundamental things have happened which I think have given increased visibility to the migrant health program.

First, we have come up here asking for the largest dollar increase in this program since its history, going back to 1963.

The CHAIRMAN. I congratulate you on that.

Dr. CAVANAUGH. Second, sir, at the time of consolidation of many grants throughout the executive branch, we are up here this morning seeking a 2-year authorization for a separate migrant health program.

The CHAIRMAN. I congratulate you warmly and sincerely. I just wish the people over in the educational branch of your department down there could be as successful in what the Bureau of the Budget does with the bilingual education program.

You have come up here, as you say, asking for the largest amount any administration has asked for.

Over in the Bilingual Education Division the Bureau of the Budget is cutting it to pieces. I don't mean it is worse than in previous years. It is the same level of whacking away as in the past years.

Senator Dominick?

Senator DOMINICK. Thank you, Mr. Chairman.

I have had a continuing interest in this situation, Doctor, for a long period of time. I am delighted that we are making progress. I congratulate the administration for asking for more money to expand this program. I think we need it. I want to ask you some questions on trends.

I had some verbal testimony given to me privately in Colorado that it seemed as though the pattern of migrants was beginning to change, that there was more stability, that they tended to go to an area and stay there as a home base. They might takeoff from there during the crop season, but they would come back to a particular spot as a home base, and many times even leave their family and children there while they were gone.

What do you think about this? Is there any validity to this?

Dr. EGEBERG. I think Miss Johnston would be best able to speak to it.

Miss JOHNSTON. I think there has been some settling down year after year for the last 20 years, and many small communities in Colorado, Michigan, Wisconsin, Minnesota, and other places now have small enclaves of Spanish-speaking people in their communities, people who used to live in Senator Yarborough's State of Texas.

But they have changed their location and they now live in some of the northern areas. Some of these people continue to migrate. They may migrate only within the State or they may migrate across several State lines. But they migrate from a new home base.

I don't think the number is so great as to change the picture materially for the whole United States at the present time. But there has been a changing pattern of migration over the years.

This is just the manifestation of that kind of change.

Senator DOMINICK. Let me ask you another question.

Do we have figures in terms of year-by-year progressions as to whether the number of migrants are increasing or decreasing?

Miss JOHNSTON. The Public Health Service has relied on the Department of Labor and the Department of Agriculture estimates primarily. The Department of Labor counts chiefly the workers. They are not as interested in counting the nonworking dependent who may follow the worker.

The Department of Agriculture estimates are based on the current population survey. They do an oversampling in selected counties. I believe their total interviews number about 300 or so for farmworker families that migrate.

They blow up their total national estimate from these 300 or so interviews. We could check and find out precisely how many interviews they are conducting now.

Then we do have estimates provided each year by the grant-assisted projects.

Senator DOMINICK. Do they estimate that the number of workers are increasing or decreasing?

Miss JOHNSTON. They show a fluctuation from year to year depending on crop conditions, economic conditions and so forth.

The 1967 figures, as I recall, from the Department of Agriculture, are that there are about 276,000 workers. But when you take into account the number of family dependents who went with the workers, it brings the number up to around 936,000. That is awfully close to 1 million. It is about the same as it has been in the last few years.

Senator DOMINICK. The number of wetbacks has substantially increased in the last couple of years, has it not?

Miss JOHNSTON. You are referring to the so-called illegals who come in from Mexico without the benefit of a green card or a passing card of some kind?

Senator DOMINICK. That is correct.

Miss JOHNSTON. I think the information on that picture would have to come from the Immigration and Naturalization Service.

Senator DOMINICK. I gather from your statement that there are estimated to be 276,000 workers but 936,000 total. Part of our major problem, then, is the dependents—wives, children, mother, father—who go with the workers?

Miss JOHNSTON. That is right. Of course, in some of the northern work areas when there is a lot of work available the women and children work as well as the men.

Senator DOMINICK. I understand that. I have always been somewhat concerned that the bracero program was cut off. We did not have this problem with it.

Just for the record, I want to point out that in the bracero program, the people were selected by the two governments and brought in under contract. Their wages were guaranteed and they were given better conditions. They didn't have their families with them. When they went back to Mexico, they probably had a larger income than most of the people in their area.

It has always seemed to me to be a shame that we have gotten away from that and moved into a situation where you have people coming in illegally and where you have many more of the social problems that have been referred to here.

That doesn't mean we don't have to do something about the social problem, but it does mean we might have been able, by another approach, to cut it down some.

Doctor, I wonder if you could tell me, or Miss Johnston, or someone: out of the 100,000 field inspections and follow-up visits which you referred to in the labor camps, have you any idea how many camps were closed down because of failure to meet the sanitary rules or what the enforcement action was?

Dr. EGEBERG. I had that but I have forgotten.

Miss JOHNSTON. We might be able to get you the number of camps that were closed down. The process usually used by the sanitarian is to get compliance, not to close down camps. He needs to get compliance because the housing is needed and there is a shortage of the migrant farm labor housing in many areas.

If you close down the camps or destroy them, you may have people going back to ditch banks and camp sites that are even worse than some of these dilapidated camps.

Senator DOMINICK. Let me ask another question. Do we have enough of a pattern of the migrant motion, the best way I can put it, so that we would have a good enough idea in certain areas of the country that we could afford to put up federally constructed housing for the migrants?

Miss JOHNSTON. I think this is one of the solutions that has been suggested in the past. It keeps coming up. I think this is something that some other expert would have to respond to.

As far as the need for housing is concerned, I think there is a need for better housing than exists in many areas. I think if we had better housing this could contribute to improved health status of the people.

Senator DOMINICK. Does anybody on the panel have any comments on this other than Miss Johnston?

Dr. CAVANAUGH. Senator, we have discussed the adequacy and inadequacy of housing for a number of years across the country. Many people attribute the lack of good, sanitary housing as one of the major causes of the health problems that the migrants face.

In terms of the advisability of a Federal construction program in this area, I don't think we would be prepared to comment at this time.

We would be happy to provide information at a later date for the record. I would say this, in answer to your specific question: Yes, I think there is data today that would indicate where one could construct Federal housing for migrants where it would be utilized to the maximum.

Senator DOMINICK. I wonder if for the purpose of our hearing record, Mr. Chairman, we might get that data so that we would have some idea where housing might be most suitably used if we ever get to that position.

The CHAIRMAN. Would you supply that for the record?

Dr. CAVANAUGH. We will be happy to, Mr. Chairman.

(The information subsequently supplied follows:)

NUMBER OF MIGRATORY FARM LABOR CAMPS CLOSED

Approximately 1,450 labor camps in 30 states were closed during the past year as a result of camp inspections by state and county regulatory agencies, and subsequent failure to correct deficiencies to qualify for operating permits. In other instances pressure on growers to comply with regulations resulted in their decision not to reopen some camps. Increased mechanization of farming operations is a factor of growing importance which also accounts for the closing of a number of farm labor camps.

It is estimated that half of the closures were the outcome of some type of legal action resulting from inspections made by migrant health project sanitarians. Usually the legal action was the denial of a permit or license to operate because of failure to comply with existing legal requirements.

NUMBER OF AREAS WHERE HOUSING IS NEEDED

At least 170 counties using migratory farm labor need external financial assistance for the construction or major rehabilitation of labor camp housing. In each of these counties, approximately 1,500 migrants are now housed for part of each year, the majority in housing that is substandard when evaluated against the labor camp regulations issued by the U.S. Dept. of Labor. Several hundred additional counties with a temporary influx of migrants have poor housing conditions to a lesser degree.

Senator DOMINICK. Dr. Egeberg, can you give any kind of an estimate on what the overall cost would be to provide the specific improvements to migrant health which you call for in your statement?

Dr. EGEBERG. One can always use a great deal of money when it comes to health, so one looks at it as a balance between what is feasible both from the point of money and in people. You can't just buy it; you have to begin to get people in to do the job.

The vast discrepancy between an average of $12 a year for health per migrant versus an average of about $250 for the rest of the country would indicate we have a long way to go.

We feel that the $15 million being asked for this year would be a very constructive and useful step in the right direction. While we probably could use more, it may be just about the right amount as far as our being able to get the people to do the job.

Senator DOMINICK. On page 8 of your statement, you said something which always jars me.

For the record, I thought maybe I better bring it up. You ask for indefinite authorization. There is a practice on this committee called the Dominick rule. I don't let anybody put in an open-ended authorization if I can possibly prevent it.

Most of the members of the committee agree. I would like some estimate on what we would need.

Dr. EGEBERG. We already have written the House suggesting possible dollar limitations. Obviously, we were not too happy with that either.

The new letter to the House subcommittee goes along with the committee's recommendation of $20 million the following year and $25 million the year after that.

Senator DOMINICK. That sounds like a reasonable approach to me.

I have a note from the staff which I think is worthwhile bringing up.

You refer to the problems of infant mortality. Immediately preceding that, you say 18 percent of the babies are delivered by midwives and the infant mortality rate is conservatively estimated at one-fourth higher than the national average.

A person reading that might come to the conclusion that this is the kind of a problem caused by the midwife as opposed to utilization of other types of medical help for births. Yet we have been asked in other cases to increase the paramedical people, including midwives.

Dr. EGEBERG. I think if you will call a midwife an obstetrical technician you would find there would be a great surge in this direction. I believe the term midwife often refers to somebody who inherited that term primarily because she is older, has been through many childbirths and does not really have any background of scientific training.

The scope for midwifery is great, and I think it is the main reason that our statistics are so bad in this country as leaving us 15th in infant and child-maternal mortality. It is because in large areas among our very poor we have not had trained midwives, whereas they have had them in European countries that do a better job than we do.

I believe the obstetrical profession see this. They are taking positive steps towards seeing that there is a standard for an obstetrical technician and are going to extend their efforts in this direction.

Senator DOMINICK. In other words, what you are doing is to try to develop a definition which would distinguish between the term "midwife" as used here and an obstetrical technician?

Dr. EGEBERG. Yes, sir.

Miss JOHNSTON. The reference in that paper, I am sure, was to the granny type of midwife, the person who sometimes practices without any supervision whatever.

The migrant health project staff members in some of the areas where these granny midwives practice are trying to bring them in and help them do a better job so that the infant mortality rate, hopefully, will improve somewhat in some of these areas.

Senator DOMINICK. I have just one thing for the record.

I think I should defend our sheep producers in Colorado and Wyoming. They are mostly Basques that were brought in under special permit from the Labor Department.

In almost all cases they are single, they are alone, they take care of themselves, and they are pretty tough people.

So in defense of our Wyoming and Colorado sheepherders, I want to tell you they are Basques and pretty good people.

The CHAIRMAN. I will have some of our people from the San Angelo area come up and shear those sheep for you, Senator.

Dr. EGEBERG. Some of those Basques sometimes get kind of lonesome. On top of a mountain in the Sierras about 13,000 feet, I saw an old baker's cocoa tin and inside it was a list, "The principal cities of Spain," signed by a Basque sheepherder. That was all that was in there.

The CHAIRMAN. One time when I was young I worked my way to Europe on a boat and there were some Basques going home who had been herding sheep in this country for 30 and 40 years who saved up enough money to go back home and buy a home. They were going back after saving up for that many years. That was over 40 years ago.

Senator DOMINICK. This was one of the things that I thought was so great about the brasero program. They actually had a home base. They would go out and get a job and were well paid for it. They were carefully supervised. They didn't have problems with their families. They were also guaranteed equal wages, housing, sanitary conditions.

I think they were a far better form of foreign aid to another country than almost anything else we have done. I was very sorry to see the program cut off.

That is all I have.

The CHAIRMAN. Thank you, Dr. Egeberg, and your associates, for your contributions made and the great amount of information you have given us.

Is there any desire that Dr. Egeberg remain?

If not, he and those accompanying him may be excused to attend to other important duties.

Dr. EGEBERG. Thank you very much.

The CHAIRMAN. The next witness is Dr. James E. Peavy, commissioner of health, State of Texas, and also president, Association of State and Territorial Health Officers.

STATEMENT OF DR. JAMES E. PEAVY, COMMISSIONER OF HEALTH, STATE OF TEXAS, AND PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

The CHAIRMAN. I welcome you as health commissioner from my own State. I am glad to see you are filling that great office with great energy and diligence.

Dr. PEAVY. Thank you very much, Senator Yarborough.

Let me say first of all, it is indeed a privilege to be invited before this committee and to discuss one of the problems that we have not only in Texas but throughout the Nation.

I am appearing here today not only as commissioner of health for the State and Territorial Health Officers.

I would like to urge enactment of Senate bill 2660, a bill that would extend and otherwise amend certain expiring provisions of the Public Health Service Act for Migrant Health Services.

First of all, let me say a few words about the Association of State and Territorial Health Officers. Although the First Annual Conference of State Health Officers with the Surgeon General was held in 1903 it was not until 1942 that ASTHO was founded.

Following the passage of the Social Security Act of 1935, various health officials began expressing the need for an organization through which the States could be responsibly represented on matters concerning Federal health grants.

Since its founding on March 23, 1942, the ASTHO has continued to represent the States and territories with respect to Federal grants-in-aid and health policies.

Prior to the enactment of the Migrant Health Act in 1962, few concerted efforts were made at the national level to cope with the health problems presented by the Nation's migratory farm labor force.

Numbering more than a million persons, migrant farmworkers and their families are in the lowest economic stratum of the U.S. population. Their situation has been studied in much detail by individuals, organizations, governmental agencies, and commissions.

Each year, new evidence of their plight has accumulated. Their mobility, low economic status, language difficulties, and cultural differences intensify the health problems that afflict them.

I know that you and the members of this subcommittee are familiar with the mortality and morbidity rates for migrant agricultural workers as compared to the general population. The accident mortality rate for migrants is nearly three times that of the United States.

Migrants also suffer needless deaths and disabilities due to infectious diseases that can be prevented or controlled. Death rates due to tuberculosis, influenza, and pneumonia among migrants are twice those of the general population.

The vast majority of migrant agricultural workers reside during the nonworking season in the southern part of the country where the minimal need for well-insulated housing, heating, and heavy clothing helps to relieve some economic pressure.

Generally in his home base area he is totally indistinguishable from his nonmigratory neighbor who is usually of the same ethnic or racial group. The married worker generally accepts migratory status because of economic necessity.

A substantial number of the migrants in this country come from Texas. Most of these are concentrated in an area below San Antonio extending to the Gulf of Mexico on one side and down to the border. We also have some migrants that come from El Paso.

Most of the migrants leave their home base in this particular area in April or May and then return to their home base again in October, late October, and November.

Our records indicate hat the annual size of the migratory family is six. In Texas they have an estimated income of around $1,600. So, obviously, this presents many problems in the way of health status of the migratory population.

Certainly, migration penalizes a farmworker in many ways. It prevents his establishing permanent residence and normal home life. Frequent and enforced disruptions in the continuity of education of migrant children result in retardation and encourage school dropouts.

The intent of legislation included in the Migrant Health Act has aimed at providing public health and medical care services for those Americans defined as "migratory."

The misfortunes of the migrant worker, however, cannot be singled out as more far-ranging or severe than those of seasonal farmworkers. Both occupy the lowest socioeconomic status and are equally lacking in medical care.

And as no true distinction can be drawn between their needs, neither is it possible to effectively distinguish between their ability to meet these needs.

In a 1962 California survey it was possible to compare the incomes of migrants with local nonmigrants. It was found that 62 percent of

local seasonal agricultural families who did not travel reported earnings of less than $2,000 a year; while 50 percent of those who outmigrated, and only 40 percent who migrated intrastate, earned less than $2,000 a year.

Thus, there were more local seasonal agricultural workers in the lowest income level than any one type of migratory worker.

Additionally, it was found that there were more workers in the highest income bracket among outmigrants than among local workers. Workers who remained at home base all year paid an economic price for their decision.

A program of comprehensive medical services for all seasonal agricultural workers without regard to their residency status is needed. This association recommends, therefore, that S. 2660 be amended to include seasonal agricultural workers and their families as eligible to receive health services in the same way that migrants and their families do.

We are particularly anxious in my own State of Texas that this bill be passed and be properly funded.

At the present time, we have 27 projects in the State of Texas. One of these is a statewide project and 26 are local projects. These are funded by Federal funds and also supported by State funds and personnel.

Many of these are cooperative efforts by the local county medical societies. In fact, each one of the 26 areas has the approval of the local society and the active participation of the medical society.

We have one project funded entirely through the local medical society and supported entirely by them. Twelve of these projects are in local health department jurisdictions where they receive services from our full-time local health units.

Fourteen are in areas where we do not have any full-time health services and, therefore, this is about the only type of health services that these migratory workers receive.

I think this program has been a very commendable one over the years and considerable progress has been made since the first enactment of the law in 1962. The first funds were received in Texas in June 1963.

We have made considerable improvements in sanitation and hospitalization of these families, and the provision of outpatient medical care, and certainly in public health education.

We do feel that much remains to be done, and we are quite anxious to continue this program and expand it if at all possible.

The provisions of S. 2660 would authorize $20 million in appropriations for 1971, $25 million for 1972, $30 million for 1973, $35 million for 1974, and $40 million for 1975.

These authorizations, if fully funded, would permit substantial progress in improving the level of health among migratory agricultural workers. Less than one-third of the migrants are now being provided health services through the program.

In Texas, last year we had around 160,000 individuals that were included in all three projects. Undoubtedly, this does represent one-third of the migratory population in the State of Texas.

Thus, it can be justified that present appropriations should be tripled to extend the existing level of services to all migrants—this would amount to about $25 million per year.

If the program were extended to seasonal agricultural workers and their families, the authorizations for appropriations should be increased.

If this were done, we would recommend that the authorizations be increased to $30 million in 1971, $45 million in 1972, and $50 million in 1973.

The addition of seasonal agricultural workers and their families would add 2 million individuals to the 1 million migrants and their families that are now eligible for services.

In concluding, let me express the appreciation of the Association of State and Territorial Health Officers to submit our recommendations on S. 2660. We urge its enactment with the recommendations that I have proposed. I will be glad to answer any questions.

I would also like to submit a copy of the annual report of 1968 of the migrant health program in the State of Texas. I am sure, Senator Yarborough, you already have a copy, but we have some additional ones here if anyone would care to have a copy.

The CHAIRMAN. Thank you, Doctor.

Dr. Peavy, I believe you are accompanied by a distinguished Washington resident who has been very active in the health field.

Dr. PEAVY. Yes, sir. This is Mr. Bob Barclay, from our Washington office.

The CHAIRMAN. We know of his good work here with Lister Hill. If you people hadn't lured him away, we were going to try to lure him to staying on with his great expertise.

I congratulate you on your leadership in wanted to do something for these seasonal farmworkers in addition to the migrants.

We are handicapped, though, by the fact, as you point out in your prepared statement, less than one-third of the migrants are now being provided health services through the program.

It seems to me that we would make more progress with the migrants, who are the most disadvantaged of all since they have no permanency. We need to get the program fully funded and get better care for the migrants.

After all, it seems that though the seasonal workers are earning less than the migrant workers, they are in one place and have certain advantages, being known to the local officers; generally, a seasonal farmworker will have some identity with some public officer he can go to, a county commissioner or somebody, who can help him get in the county hospital. He has some roots there that will help him somewhere along the line, an advantage that the migrant worker doesn't have at all being in a strange environment.

Dr. PEAVY. I am in complete accord with that. I think you are exactly right.

The CHAIRMAN. What do the highest paid migrant farmworkers earn?

Dr. PEAVY. I don't have that information.

The CHAIRMAN. I don't have the actual data, but I think probably the sheepshearers are the highest paid. They come from southwest Texas. They start shearing sheep earlier in Texas, of course, because it is warmer. They shear northward to the Canadian border and then go back.

The sheepmen around San Angelo are very much concerned that though they earn more money, they say there are no young sheep shearers. You just can't get young Mexican-Americans to go into it. They don't want to be gone for months from their family on the trail northward.

They told me that is one of the big problems. They will not come in to shear the sheep despite the high pay.

Another question asked by Senator Dominick concerned the settling of the migrant farmworkers in localities where formerly there were no people of their ethnic background or linguistic background.

During August, I spent a week on the high plains of Texas, from Lubbock north, primarily in the Amarillo area. I visited some 25 counties. I hadn't been in some of those counties for 3, 4 or 5 years.

They said, "Things are not the same as when you were here last. We have a new population of Mexican-Americans here. You walk down the street and you will hear Spanish spoken now."

I had never heard that before. There were very few Negroes and very few Mexican-Americans. The Mexican-Americans came through as migrant workers. They saw the towns and liked them and after working a few weeks went back and got their families and settled. They didn't have much money but they just settled and went looking for odd jobs.

The people were rather perplexed as to whether they had enough jobs. They knew it meant more expenses for schools and so on. It was just a new element in the community that they never in their thinking thought would come.

How are these people treated there? Do you still treat them under this program as migrant workers until they stay a certain number of months?

Dr. PEAVY. They would probably just change their home base and probably still continue to be migrant workers. I think they would continue to be under the program.

The CHAIRMAN. In a city of over 10,000, they said they never had people like that living before in the town. They just started settling there. There are quite a number who settled in Hereford. In fact, most of the people who work in the sugar beet mill are of Mexican-American extraction.

Then they have moved north of there to the northern tier of counties of Texas. You are familiar with that, I assume.

Dr. PEAVY. Yes, sir. I think their housing would have something to do with it. They probably have better housing and better facilities so they stay.

I think you and I both are quite well aware of some of the conditions under which they live at their home bases. This would certainly be an improvement.

The CHAIRMAN. This is no Government program. They got no help. They just piled their possessions on an old car and took their families, moving hundreds of miles.

Dr. PEAVY. That is right.

Senator DOMINICK. That is the old American, free enterprise, frontier spirit.

The CHAIRMAN. Yes, sir. They work at odd jobs, at anything they can do.

Senator DOMINICK. I brought that up because I noticed in our area now we have a number of people who had been thought of as migrants but they are not really migrants. They are settled in.

The CHAIRMAN. Dr. Peavy is recommending that these be considered equals with seasonal farmworkers. The data shows that less than one-third of the migrants are now being provided health services through the program. I think it is a group of people who need help.

We value your recommendation but it is a question of whether we have enough money, unless we can get the money that you recommend, Dr. Peavy.

Dr. PEAVY. Of course, if it isn't, I certainly agree definitely with you that it should be concentrated on the migrants. This was if the funds were available.

The CHAIRMAN. It would be nearly impossible to get 100 percent of anything.

Dr. PEAVY. That is right.

The CHAIRMAN. But certainly there ought to be health care available to more than one-third because these migrants have their families with them, generally.

Dr. PEAVY. Yes, sir.

The CHAIRMAN. One other factor you had here that I was not familiar with, a very cogent fact, is the second sentence in the second paragraph on page two where you are talking about the health conditions; and you say the accident and mortality rate for migrants is nearly three times that of the United States.

I think that is a shocking figure.

Dr. PEAVY. I think a part of this, too, is due to the fact that they migrate in these older, second-hand cars, as you are quite well aware. Naturally, they are more subject to accident risk than somebody with better transportation facilities.

Of course, some travel by bus but I would say a good part of them travel in old, broken-down, second-hand cars.

The CHAIRMAN. You see today the migrant worker taking his whole family with him in an old car.

Dr. PEAVY. That is right.

The CHAIRMAN. Senator Dominick?

Senator DOMINICK. I think the testimony Dr. Peavy has given will be helpful in our consideration of this, Mr. Chairman. I congratulate him. I think his comments on the seasonal farmworkers are good.

I do wonder a little bit about your proposed authorization. You are really tripling the number of people we are going to be servicing and yet you are not tripling the authorization.

Dr. PEAVY. I realize this, Senator. Of course, as Dr. Egeberg brought out, we can certainly always use any amount of funds in programs like this for treatment and health facilities. We settled on this figure really as sort of an arbitrary sort of figure, knowing that we could be utilizing more funds if available.

We felt this was all of the funds we would be able to get at the present time.

Senator DOMINICK. It is my recollection that seasonal workers are also covered under the OEO act, are they not?

Dr. PEAVY. I believe so.

Senator DOMINICK. We may have some cross action there.

What is being done in the area that Senator Yarborough just spoke of by the State and local authorities to assist these people in health matters?

Dr. PEAVY. As I brought out, Senator Dominick, I think most all of these programs are cooperative programs. A lot of the funds or I would say most of the funds are Federal funds, but local people are also putting up personnel and putting up considerable funds themselves.

As I brought out, but not in my written testimony, in each one of these programs, and we have 26 in the State of Texas, the county medical societies all approve and participate in the programs. We have one area in particular that is funded and financed entirely outside of the Federal funds, staffed entirely, by the local medical society.

So this is really a cooperative program of State and Federal governments.

I might mention that in our own health department all of our resources in the State health department, all of our programs, go into the migrant health program, and although we don't specifically allocate funds just to the migrant health program we are contributing a whole lot of services in kind to the overall migrant health program.

I think this is true throughout the State. You will find that 12 of these local projects are with local health departments and they are contributing significantly.

For instance, all the immunization material is made and furnished by our department. This type of activity doesn't show up in the funding.

I would like to see more funds available from all sources to help the plight of these migrant workers.

Senator DOMINICK. When they move into this type of new locality, what effect do you find on the school situation there?

Dr. PEAVY. I might mention in our State that we do have a special project. This is an educational program. This is a short type of program just for the migrant worker. When he is in his home base he goes to school from November until April in a speeded-up type of program.

I am sure when you add people who are permanent residents in a given area, it does increase the amount of funding that has to be put up by the local area to take care of the influx of the migrant workers.

But if this has been a major problem, I really haven't really heard about it. I am sure it does produce some extra burden on the local school system to be able to take migrant workers, but I don't think it has been of tremendous importance as yet, Senator Dominick.

Senator DOMINICK. Is your State educational fund or your assistance from the State extended so that more aid is given to those districts which are impacted with these people?

Dr. PEAVY. Yes, sir. I am sure Senator Yarborough is better acquainted with this than I am, since this is in the education area rather than the health area. We do have a form of a grant system in the State of Texas so that if there is an increased need for funds, then they get more funds out of the State government. It is put on this basis. I would think there would be increased funds.

The CHAIRMAN. Senator Dominick, under our system, the local school district obtains most of its funds from the State. It used to be that local taxation was the source.

It is based on attendance, not enrollment, average day attendance.

The State sends out auditors several times a year. They have to keep their books every day. The local school district puts the pressure on superintendents, teachers and so on, to keep every pupil they can in the school.

If a pupil drops out, they don't get as much money for their school. They try to get as many children to come so that they can get more money.

The Indians get a grant under the Federal Elementary and Secondary Education Act and when the children register they just get the money and let the children drop out.

In Texas, they do try to get the Mexican-American children in school. I hope we can get better funding.

Senator DOMINICK. As you know, I agree with you in that reason and joined you in sponsoring the Bilingual Education Act. I hope we can get moving on that. I am convinced that just providing medical services as such is not going to really solve the problem. It will help but it will not solve the problem. We have to get the educational level up as well.

The CHAIRMAN. And these children are bright children. I have talked to many teachers who teach these Mexican-Americans and they are very bright students.

Senator DOMINICK. I have nothing further.

The CHAIRMAN. Dr. Peavy, your recommendation about the seasonal workers would triple the number of people from 1 to 3 million, as Senator Dominick pointed out. Of course, if we could get the amount of money you request appropriated, it would triple the present appropriations.

Our problem now is the lag between authorization and appropriation. We are going to weigh this recommendation.

This year, of course, there is a shortage of money. The earlier budget recommended $8 million which would only reach one-third of the migrant workers. I think yours is a good recommendation if we could get the money.

Thank you very much.

Dr. PEAVY. Thank you.

The CHAIRMAN. The next witness is Dr. William Dougherty, assistant commissioner for local health services, New Jersey Department of Health, and representing the American Public Health Association.

STATEMENT OF DR. WILLIAM DOUGHERTY, ASSISTANT COMMISSIONER FOR LOCAL HEALTH SERVICES, NEW JERSEY STATE DEPARTMENT OF HEALTH, ON BEHALF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Senator DOMINICK. Mr. Chairman, unfortunately, I have another meeting. We have a witness from Golden, Colo. Mr. William Scholes, who has a statement. I am sorry I am not going to be able to be here when he presents it.

I thought I would make that comment for the record. Unfortunately, I do have this other meeting to which I must go.

The CHAIRMAN. I regret that, Senator Dominick. Had I known that, I would have placed the gentleman ahead of Dr. Peavy.

Senator DOMINICK. Mr. Scholes has a statement to present to the committee, and I look forward to reading his testimony at a later date.

The CHAIRMAN. Thank you, Senator.

Dr. Dougherty, would you proceed?

Dr. DOUGHERTY. Senator Yarborough, I wish to thank you for the opportunity of appearing in behalf of the American Public Health Association.

I sat in the audience and I listened to the interchange. I would like to say that a person from a local level in a State such as New Jersey appreciates the empathy and the understanding which the chairman has demonstrated this morning concerning the plight of the migrant worker.

The CHAIRMAN. Thank you, Dr. Dougherty. This is an educational institution here, educating Senators. I was astonished to come here and start serving on these committees to learn of your great agricultural production in New Jersey, in your vegetable crops there.

Before you start your statement, let me ask you a question. You have migrant farmworkers, I know. Senator Williams, a member of this committee, has been chairman of the Migratory Labor Subcommittee of the Senate for years until he moved up this year to chairman of the full Labor Committee of this committee.

Where do most of your migratory farmworkers come from?

Dr. DOUGHERTY. We obtain our labor force from three different sources. The first source, and now the predominant one, is the Commonwealth of Puerto Rico.

The CHAIRMAN. Are they seasonal workers who settle there? Do they come and work during certain harvest seasons and leave? Are they migrants?

Dr. DOUGHERTY. There are several interesting arrangements. The first is a contract arrangement between a cooperative of farmers who band together and form a negotiating unit to work with the Department of Labor in the Commonwealth.

They negotiate each year a contract which contains many specific provisions concerning wages per hour, piece rate wages, living conditions, including nutritional requirements, and so forth.

In other words, the labor negotiator for the worker coming from Puerto Rico is, in fact, the Commonwealth Department of Labor. These people come under the contract, work a specific period of time, and return to Puerto Rico.

By and large, I think they are explorers. They come with a certain guarantee of transportation, fixed wages, living conditions, fairly well stabilized.

Having looked at the scene, I think they return as independents. In time they may bring their families. They may come then as independent contractors, bringing their families with them and live in the State for a period of time and perhaps return to Puerto Rico.

Ultimately, some of them will settle out and having settled out they then form—Mrs. Johnston used the word "enclave." I think that is probably not true in New Jersey. They are beginning to form real communities, small cities within cities, groups of people who are becoming reasonably well educated, reasonably well active politically and socially in the community.

For example, in one of the communities where I work I stopped at the opening of a prenatal care center and a restaurant nearby was completely run by Puerto Ricans. The menu was in Spanish and one had to speak in Spanish to be fed. So there is a tremendous movement of persons from the island to the State.

The next group of people that are important to us are the nonwhite Negro workers who come from the South, primarily from Florida.

These individuals come as family units in crews, generally under the administration of a crew leader. These people bring with them many problems. Later I will speak about the seasonal farmworker and I would like to refer to this group of people.

The CHAIRMAN. Does the second group go back home when the season is over or tend to settle in New Jersey?

Dr. DOUGHERTY. It is very interesting. When I first became associated with this program in 1956, I thought of the Negro worker as a person who stopped en route from Florida, through South Carolina, through Virginia, into Delaware and New Jersey, and perhaps on his return he made the same stops.

Many of these families come nonstop from Florida, directly to New Jersey, and their families come with them. The youngsters go to school in the New Jersey summer school system and on Labor Day, or shortly before, the New Jersey summer school stops and the buses or other means of conveyance are loaded with youngsters and mothers and away they go to Florida so that they are in Florida to enter the school system there.

We have very few youngsters now who hold over. There are a few, particularly in families where the worker is an excellent worker and provisions are made for his long-term employment into the deep fall.

The third group of workers are those individuals who we hire or recruit locally in the major cities, such as Camden, Trenton, Perth Amboy, and the adjacent cities of Philadelphia and Wilmington.

These workers come in large convoys every morning to work in the field. They, in general, are the responsibilities of the communities from which they emanate, or where they reside.

Therefore, they do not constitute a major problem in terms of our health services.

But the other two groups we have to deal with, and the primary people that we deal with are the Negro farmworkers and the family associated Puerto Rican workers who are independents.

The Glassboro Field Service Association contract contains adequate provisions for medical services, hospitalization, and doctors' services.

The CHAIRMAN. When a Puerto Rican comes as an independent he just comes by himself without contract representation by the Department of Labor of the Commonwealth?

Dr. DOUGHERTY. That is correct.

The CHAIRMAN. When he comes as a contract laborer under the contracts negotiated by the Commonwealth of Puerto Rico, I believe his family is not with him.

Dr. DOUGHERTY. A single male worker, generally for a specified period of time.

The CHAIRMAN. Let me ask you about the third category. You heard Senator Dominick talk about the brasero program and the termination of it.

In Florida, they have people come from Jamaica to harvest the citrus crops.

It has been the contention of the farm employers that you couldn't get people from cities to come and work on the farms.

In that third category, those who come out from the cities in the morning and work and go back to their permanent place of abode in the cities, are they in any appreciable numbers? Are they a sizable portion of the labor force?

Dr. DOUGHERTY. They are a sizable portion. They constitute anywhere from 3,000 to 5,000 of a 25,000 work force.

The CHAIRMAN. Do you find that number increasing or decreasing, those who come from the cities?

Dr. DOUGHERTY. Let me explain that there are reasons that will cause that work force to increase. In our emphasis upon sanitation, for example, we require that every migrant labor camp have a potable water supply.

This means that the well system has to be examined structurally to make sure that it is sound, and that the water sampling is adequate.

This year, as of January 1, 1970, the migrant labor camps in New Jersey will be required to have approved sewage. That means the ordinary wash basins, commodes and shower systems will have to be drained into a subterranean system, a septic tank, or where the camp is located in relationship to a city the camp's sewage must be drained into a city sewage system.

This we want to do because we wish to eliminate the privy. We feel that in an advanced State, with massive problems of water pollution, and so forth, we cannot afford to have contamination of the soil.

We think this will provide better living conditions, but, it is also an expensive undertaking for the farmer who may hire three, four, five, or six workers and maintain a small camp.

The installation of a separate sewage system for the service of those workers may be too expensive.

Therefore, he may elect to close his camp and to seek employment of people through the day haul labor activity. This, we believe, is going to happen in greater and greater numbers.

The other factor that will probably change is the employment of larger amounts of machinery. Fewer people will be required to run the machinery. They will have to become more expert. They will get better wages.

I feel personally that when you begin to find that local people are servicing agriculture that there will be a formation toward unionization, collective bargaining, and the rights that other members of the industrial establishments of this country enjoy.

The CHAIRMAN. You feel when that comes then your need for migratory labor from other areas will decline because people in the cities would come out and want to do that work when it pays better?

Dr. DOUGHERTY. That is correct. Wherever we have seen an increasing mechanization, we have seen a diminishing number of migrants.

The CHAIRMAN. Thank you.

Doctor, you can present your statement in your own way.

Dr. DOUGHERTY. Also, before I start that statement, may I say one thing that I think needs to be said.

I have worked with Helen Johnston since the inception of this program in 1963. I think that she deserves a word of commendation because without her compassion for the migrant worker, without her deep dedication to the migrant worker, I don't believe we would have progressed to the point at which we now find ourselves.

I believe that her points of view concerning a well organized start, to reach out into the communities of this country where the agricultural economy is divorced from the urban scene, really, and to further the activities of the migrant labor program are sound.

The CHAIRMAN. I am glad to have this testimonial for her—a testimonial on what the program for the health of migrant workers has meant.

I am concerned that this combination, with the decline of the number of professional personnel in the Migrant Health Division and the pitching of everything into one area, will cause difficulty.

Under this partnership for health, do you think the migrant worker will have better attention and care under that or less?

Dr. DOUGHERTY. My personal feeling is that there would be less drive, less direction, less reach out, less coordination.

I might also say that I firmly believe in the concept of a separate identity for the migrant labor health program.

I do not believe that medicaid is presently prepared to handle this type of undertaking, one of the reasons being that one has to establish your position as categorically assisted.

I have heard you speak about attitude of strangers. The migrant being a stranger he is seldom readily accepted. I can present from the records of our department statements concerning this attitude, with documentation to back it up.

In terms of the 314(e) request operation or project grant request, I think the migrant program would be lost because that program operates for those people who have the greatest voice.

It operates for those people who can organize and bring pressures to bear in the planning process. I have no objections to all of this. I think it is a necessary development in our country.

But, nevertheless, if you are representing or working with a voiceless group of people who are not going to be about when the councils take place, then I say you have to give to the migrant the protection of an on-going identified program.

I would agree with the concept of a 3- to 5-year program because in planning health services it takes years, literally, in the rural areas of this country, to evolve a system.

I have not had experience in areas more rural than New Jersey, but I can tell you that we have worked with some counties for 3 to 5 years to (1) develop a county health department which you would expect they would have had years ago and (2) to get them to assume responsibility for the migrant program.

The CHAIRMAN. That is a separate project, isn't it? Once you get the county health unit, without some encouragement or pressure or request, they don't immediately include the migrant worker.

Dr. DOUGHERTY. That is correct. It takes a long time to get the people locally to accept the migrant as being their responsibility. He is someone else's responsibility, far away from us, is their feeling.

The CHAIRMAN. Even when he decides to settle in that community, they do not accept him as part of that community immediately, do they?

Dr. DOUGHERTY. Senator, I met in August with some angry Spanish-speaking people in a city in our State who said that they are not accepted, a vast number of people, probably around 4,000 or 5,000.

They laid it out, that the health department was not providing them as adequately as they should, that the local hospital was not accepting them, that there were no rovisions for Spanish-speaking people within the hospital in the way of interpretation or multilingual capacity to communicate.

These people have come there. They have settled there. I believe their early roots were migrant workers who found that there was a fertile source of employment, work that they could accomplish, and work that would allow them to progress and develop.

The CHAIRMAN. How long had they lived there in August when you were meeting with them?

Dr. DOUGHERTY. For some people they are in their second generation. I would also say that many of these people have difficulties in the educational system. That is another factor that we have to approach and overcome.

I heard you speak of it this morning. I think it is worthwhile mentioning that there are many manifestations that Spanish-speaking in this country are not receiving the full opportunities that they deserve.

I raised the question with one of our medical schools, as to the number of Spanish-speaking, Puerto Rican people who are being admitted to medical colleges. There was no answer to that question.

I have checked in the high schools as to the number of youngsters of Spanish origin who move forward into college and they are a relatively small number. Obviously, the source for professional people is limited. But we need these people in the future.

I think we reach that point by providing ample opportunities for both health and education services throughout the country.

The CHAIRMAN. Doctor, I haven't had a chance to read your statement yet, but if it is as good as this extemporaneous statement you have given us, it will certainly be appreciated.

Dr. DOUGHERTY. The American Public Health Association wishes to bring to your attention its deep interest in and endorsement of the intent of S. 2660.

This legislation would enable the U.S. Public Health Service to assist States and local communities in their efforts to extend health services for domestic migrant agricultural workers and their families. Favorable consideration by the Congress is urgently needed.

The American Public Health Association, with some 45,000 public health workers in its affiliated societies and branches throughout the United States, has for many years been deeply concerned about the serious need for congressional action to assist in efforts to overcome the nationwide difficulties inherent in the provision of truly available health services to these disadvantaged farmworkers.

The Federal responsibility for leadership, stimulation, coordination, and support of local health efforts for these people is as clear as is their economic importance to American agriculture.

Please find attached to this statement two resolutions approved by the American Public Health Association in behalf of the health of domestic migratory agricultural workers. These appear in appendix A. (Appears on page 40.)

The concern of this association for the plight of migrant and seasonal agricultural workers and their families is prompted by the following facts:

1. The health needs of domestic agricultural workers, particularly those migrating from their home communities, are greater than those of any other socioeconomic group in the United States.

These people have health problems similar to, but more severe than, those of stable rural farmworkers' families. Studies continue to show high infant mortality rates, high communicable disease rates, low prenatal care rates, high premature birth rates, high accident rates, low immunization levels, serious needs for dental care, and little realization of the need for or utilization of preventive and early treatment.

2. Low economic and education levels, mobility, lack of resident status, geographic isolation from medical facilities, plus cultural factors and language barriers contribute to the health problems of migrant and seasonal agricultural workers.

3. In isolated instances where the social, economic, geographic, and cultural characteristics have been taken into consideration in offering services to this group, and where funds have been made available, the improvements in health conditions among this group in various parts of the United States has been striking.

The need for improved health services for migratory and seasonal agricultural workers has also been recognized by the President's National Advisory Commission on Rural Poverty.

The Commission under the chairmanship of the then-Governor Edward T. Breathitt of Kentucky recommended in 1967 that the Migrant Health Act be renewed with sufficient funds to expand the program in terms of geographic coverage and service offered.

The Commission also recommended continuity of services with a broader definition of migrant worker to cover the entire migrant community, especially in home-base areas.

The fact recognized by the Commission is that migrant and seasonal farm workers frequently live side by side in the same community. Their status as seasonal workers and as migrant workers shifts and it makes no sense to arbitrarily cut off health services of a migrant agricultural worker when his status reverts to that of a seasonal agricultural worker.

I want to make it clear that the American Public Health Association is fully in support of the extension of services to seasonal agricultural workers and we urge adding coverage for seasonal agricultural workers to the provisions of S. 2660.

The increases in the authorizations for appropriations for the years 1971 through 1975 are adequate if only the health needs of migratory agricultural workers and their families are considered. From the present authorization of $15 million for 1970 the limits would rise to $40 million in 1975.

The APHA believes the authorization should be increased to $60 million by 1972 so that the health needs of seasonal as well as migratory agricultural workers could be met. I would like to cite some data that demonstrates how urgent is the need for increased funds.

Only one-third of the 1 million migrant agricultural workers and their families are now being reached through grant-assisted projects. The addition of seasonal agricultural workers will add an estimated 2 million to the population to be served.

The estimated per capita annual expenditure for personal health services for migrants last year was less than $11 as compared to national average per capita expenditure of $250.

Migrants' use of medical care is about one-seventh, their use of dental care is about one-twentieth, and their use of hospital care is about one-fourth that of the general population.

The accident mortality rate for migrants is nearly three times the national average.

The mortality of migrants due to tuberculosis, influenza, pneumonia, and other infectious diseases is more than twice the national average.

These deficiencies among migrant workers and their families also prevail among seasonal agricultural workers and their families. If comprehensive health services are to be provided these keyworkers of the agricultural economy, it is essential that appropriations be increased.

In concluding, let me express the appreciation of the American Public Health Association for this opportunity to express our recommendations on S. 2660, and we urge favorable consideration in respect to them.

APPENDIX A

Resolutions Approved by the American Public Health Association on Behalf of Migratory Agricultural Workers

MIGRATORY LABOR

Whereas, studies in various parts of the country disclose great need for the development of comprehensive health services to the migratory worker and his family, especially the migratory farm worker, in concert with other community services such as those for welfare, education, and employment, therefore be it

Resolved, that the American Public Health Association recommend the establishment of Governors' advisory committees on migratory labor composed of individuals best informed about the fields of health, housing, welfare, education, and employment, and be it further

Resolved, that the American Public Health Association request the President and the Congress of the United States to provide adequate financing for the continuation and strengthening of Federal services through the Department of Health, Education, and Welfare directed to migratory workers and their families, including grant-in-aid programs to appropriate state agencies.

Approved by the Governing Council, American Public Health Association, October 21, 1959.

AGRICULTURAL MIGRANCY

In many of the States there are sizeable numbers of agricultural migrant laborers. Presently, many benefits available to other citizens are inaccessible or denied to the migrant. Migrant children are precluded from adequate basic education and preparation for improved vocational opportunity. Competition offered by labor imports from countries with lower standards of living has served to depress domestic farm labor opportunities and standards of living and health.

The American Public Health Association, recognizing that the migrant laborer's health and well being are parts of a broader issue regarding the total migrancy problem, requests the President of the United States to appoint a National Task Force on Migrant Agricultural Labor to:

1. Examine the problem from the point of view of labor, industry, agriculture, and community residents.
2. Stimulate the application of existing knowledge in the improvement of the health of migrant agricultural workers and their families.

3. Consider ways of utilizing new technology and other measures in the elimination of migrancy in the Nation's agricultural manpower pool.

In the interim, the American Public Health Association urges State and local health officers to develop and strengthen health programs for the agricultural migrant and his family and to seek solutions to problems of residency requirements.

Approved by the Governing Council, American Public Health Association, October 20, 1965.

Dr. DOUGHERTY. May I make a further statement?

The CHAIRMAN. Certainly.

Dr. DOUGHERTY. I spoke about the educational opportunities for the Spanish-speaking. I have also made available through another program of the Public Health Service the apprenticeship program, opportunities for dental students and medical students to work in the field of migrant labor.

I would like to quote from one of the lad's reports of the past summer:

"Extricated from the secure towers of academia and out from under the spreading apathy of middle-class suburbia, the medical students, the dental students, can acquire the community orientation that will be expected of him upon graduation."

If you are familiar with the profession, most of us want to be specialists. Most of us want to work in cities where the economic prospects are great.

There are relatively few physicians in the rural areas of this country. I feel that the migrant health program has a great opportunity if it works in conjunction with the universities of this country, to bring young medical students into direct contact with the realities of the rural life, and also it will introduce them to some of the most abject areas of poverty and deprivation that they will ever see in their lifetime.

I hope and trust that such exposure would adequately prepare them for their future responsibilities.

Thank you, sir.

The CHAIRMAN. Thank you.

I have just been handed a note by the staff that says only 2 percent of this year's medical graduates are general practitioners.

I think that illustrates what you say about the professional men who want to be specialists.

Being a lawyer, I understand that desire of professional men. They want to be specialists and be on the fee system.

If the migrant worker had more than he has and paid a bigger fee, he would be welcomed to a lawyer's office or a doctor's office faster than so-called middle-class suburbia.

Dr. DOUGHERTY. I can testify to that because the program in our State has permitted migrant workers to develop a private practitioner relationship. Once the private practitioner knows this person is able to be supported in his medical services, he develops an empathy which attracts the man.

He sells his product and the migrant buys and we have then an interchange of private practice and the individual migrant. We remove him then from the stigma, I think, of the field clinic which we used to conduct in the dusk of the evening to the private practitioner's office or to the confines of a medical practice, a family medical practice, gen-

erated in the evening within the existing hospital facilities of the community which 15 years ago, sir, I would guarantee would not have been considered or even dreamed about.

But the doctor is exposed to the people, understanding them and developing some concern for them. He has then been our greatest ally in bringing the services into the hospital.

The CHAIRMAN. Thank you very much, Doctor.

Dr. DOUGHERTY. It has been a privilege to be here, Mr. Chairman, and thank you.

The CHAIRMAN. The next witness is Rev. William E. Scholes, associate for field services, Division of Christian Life and Mission, National Council of Churches, Golden, Colo.

STATEMENT OF DR. WILLIAM E. SCHOLES, ASSOCIATE FOR FIELD SERVICES, DIVISION OF CHRISTIAN LIFE AND MISSION, NATIONAL COUNCIL OF CHURCHES, GOLDEN, COLO.

The CHAIRMAN. Dr. Scholes, proceed in your own way, please.

Dr. SCHOLES. Thank you, Mr. Chairman.

I am William E. Scholes, associate for field services for the Division of Christian Life and Mission of the National Council of the Churches of Christ in the U.S.A.

I am here to speak in behalf of the National Council of Churches, an agency comprising representatives of Protestant and Orthodox communions. Obviously, we make no claim to be speaking for these member churches nor for their members.

The viewpoints presented in this statement are based upon the official statements of the general board of the National Council of Churches, a body broadly representative of its member church bodies.

The concern of the churches for the depressed and deprived condition of wageworkers in agriculture, particularly seasonal and migratory workers, has extended over a full half century.

It was in 1920 that a group of church women inaugurated a ministry to migratory farmworkers which laid the foundation of what has come to be known across this Nation as the migrant ministry, a cooperative undertaking of the National Council of the Churches of Christ in the U.S.A., State and local councils of churches and Church Women United, and many Christian denominations and local churches.

Our interest and involvement in migrant concerns were wide, but at this time we are particularly concerned with adequate health services. This concern is of long-standing and is reflected in the policy statement, adopted by the general board December 3, 1966, entitled "The Concern of the Churches for Seasonal Farm Workers" where it states:

> The National Council of Churches directs its proper commissions and personnel to join with local congregations, local and State councils, denominations and their judicatories, and the United Church Women in planning and implementation of . . . a *ministry* of legislative action. One specific concern which has received exceedingly high priority is our call for adequate funds from federal and state sources for . . . health services, housing and sanitation facilities . . . needed to overcome the special disabilities suffered by seasonal farm workers.

Some time ago I was in a very small examining room in the most rural of settings speaking with a dedicated physician. He was there because the Migrant Health Act had made his presence possible, not

just in token payment to him, but through the community provision of facilities, assistance, and involvement.

The cooperating public health nurse ushered in the wife of a seasonal farmworker carrying a small child, probably a little less than a year old. The mother certainly had most minimal financial resources and would have had extreme difficulty getting care for her child in the nearest large town many miles away. She was obviously worried and near to tears. Even to laymen such as you and me the child was very ill.

That doctor examined the child with all the patience and gentleness possible. Money of any amount could not have paid for the care and concern he showed, for the child had the beginnings of pneumonia. They were not sent away with a prescription they could not possibly afford to purchase. They were not referred to someone else.

Before they left, the child had received a shot of penicillin which was maximum for the age of the child and the particular situation. Other medicine was placed in the hands of the mother with detailed written and verbal instructions in both English and Spanish by a bilingual aide, a woman recruited from the farm labor community.

The mother was not only told to return in 2 days, but told in detail how to contact the doctor in case of emergency during the interval.

As that mother left she said "thank you" in two languages—but it was rather the look in her eyes which counted. It was a look of relief because of her conviction that someone really cared. It is because of the true gratitude in her eyes, a look I shall never forget, that I want to testify here today.

I would like to urge, as strongly as possible, the continuance of health services to seasonal farm labor families through the extension of the Migrant Health Act. No doubt you will have ample testimony and statistics relative to the plight of the seasonal farmworker and his family.

There is no need for me to dwell again on the fact that he is among the most poorly paid of workers in our society, that he is normally excluded from the larger community, that he has none of the protections of labor contracts which usually include provisions for more healthful working conditions or health insurance plans.

Even in this age of advanced scientific knowledge, seasonal farmworkers have some of the highest rates of infant mortality parasitic infections, anemia, dental decay, TB infections, and a multiplicity of problems based on the stark fact of periods of real hunger and overall poor nutrition.

I will never forget a small boy in a labor camp in Arizona. I had been visiting a mobile health clinic provided under this very Migrant Health Act, said "hello" to the youngster, and asked why he wasn't in school.

I was informed that he had stayed home to visit the doctor. When I smiled and asked if the doctor "fixed him up" he replied, "He sure did, but I didn't eat yet." I laughingly suggested he had better get at the business of eating then, but the laugh faded as I realized he didn't think it was funny.

Further inquiry showed that he indeed had not eaten that morning, nor the night before, nor would he that noon. There was no food in their shack and little chance of any.

There was a real connection between the medical problems of this child and the way his family had to live. It was slack season, work was scarce, and they were waiting anxiously for the return of the father that afternoon in the desperate hope that he had gotten in an hour or two of work and would be bringing at least $1.50 home with him.

Seasonal farmworkers do have problems which are unique. There is seldom continuity of employment. They are by definition underemployed. Underemployment means malnutrition, poor sanitation, leaky roofs, and a consequent need for doctors care which is all too often unavailable.

It is all too often unavailable because they have little or no money for anything but food, and doctors cost money. Many of us here in this room have had doctor and hospital bills this past year surpassing the total normal annual income of a seasonal farmworker. Unavailable because, when clinics exist they are often for residents only or are held during the day when the farmworker dare not take off from the job because he needs the money.

Clinics are often as much as 50 or more miles away. Often no clinics exist—unless by way of the work made possible under the Migrant Health Act.

Counties where the problems are greatest are often seriously handicapped by shortages of funds and health manpower.

Much of my job is in relation to the migrant ministry which has been serving the seasonal farmworker for 50 years. For close to 18 years I have had personal asssociations with seasonal agricultural workers and feel that I know their heartaches as well as any outsider can.

I have personally seen the way in which clinics and other direct health services to migrants under this act have made the difference, literally, between healthy life and possible permanent health impairment or death.

I have seen long lines of fathers, mothers, and children, waiting to see the nurse and doctor.

I have seen their worried faces, and I have shared their relief and confidence after the shot of penicillin or the throat culture.

I have seen clinics which should have closed at 9 p.m. go right on until 11 p.m. because the people were there. And the doctors and nurses stayed—not for pay, for their pay was mighty little with perhaps nothing for the extra hours, but they stayed because they were needed.

I have seen tired medical staffs giving the kind of unhurried, thorough, responsible concerned care which each one of us seeks out and covets for our own loved ones.

I know of total communities involved in these efforts—the service clubs such as Rotary or Kiwanis providing space, migrant mothers serving as aides and interpreters, PTA mothers and fathers registering people and filing records, local community groups furnishing janitor service or electricity, so that as much as possible of the funds from the Migrant Health Act could go into direct clinic services, home followup, health education, sanitation enforcement, emergency dental or hospital care.

I have been deeply impressed with the fact that this one program which started small, on almost no funds, and has built very solidly on

community involvement and support of both "liberal" and "conservative" elements, on the support of the medical societies and public health officials.

The solid planning and solid growth over the years is based on broad support. Hundreds of people from the migrant ministry in State after State have volunteered countless hours in support of efforts which would be continued through this kind of bill.

Now more than 400 orders of Catholic Sisters are cooperating in a plan of local support and, along with others, are deeply concerned with the extension of migrant health services in this way.

But our experience has been that volunteers are effective only when given the training and supervision which this act provides through the specialized staff which we hope can be soon reinstated.

For nearly 5 years I served on the Migrant Health Review Committee, intimately involved in literally cutting nickels and dimes from some budgets in order to make medical service, specialized staff training and migrant involvement available to the greatest number possible.

In the field I have seldom seen money stretch as far for so many. With seasonal agricultural people in 117 counties of 35 States now being served and treated, I am convinced the relatively small amount of public funds is effectively spent.

When hernias are repaired so men can work, when arthritic pains are alleviated, and when toothaches are stopped among one-third million of the most underprivileged people, I feel this is a great human accomplishment.

However, since the other two-thirds of this group are still often without service, I would say that the extention of this bill is not only desperately needed, but the funds suggested for appropriation should be far closer to, or even above, the suggested amounts in the companion House bill.

For it is well to remember these are working funds—not funds for another study. People out there who work on local projects know what the problems are and how as total communities they can tackle them.

What they need are the funds, plus the guidance and consultation of trained specialists in the field of seasonal agricultural worker problems to help them to make the most of what is available from this source.

This is not a bill for talk—it is call for action and direct service which gladdens the heart of every citizen close enough to agricultural workers to know their problems and cares.

I would, however, raise a note of caution. That is that the funds of the Migrant Health Act should be held in a separate categorical unit with a separate and specially trained staff and administration.

I have been in field administration long enough to know the trends are toward unified budgets and unified staffs which seem on the surface to be more efficient. But in the processes of unified budgets and unified staffs priorities must be set.

And seasonal agricultural workers who are the voiceless and powerless, lacking visibility and identity, will in all likelihood be lost in the priority struggle. They need clearly identifiable grants which assure that local efforts are not diluted, with restoration of national staff

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which are trained especially for work on the special problems of this group; staff which is specifically identifiable because of their special skills around the health problems of seasonal farmworkers.

Migrants have always been "the forgotten people" and I am sure none of us want to see that happen here.

It is through this act that we see health care available where it would not exist otherwise.

Through this act we see night clinics which were at one time thought to be impossible but now operate effectively at the only time when seasonal farm workers can attend.

We see health services in churches, schools, labor camps, and so forth, supplemented where geographically possible by hospitals.

The help of public health nurses, nursing aides, sanitarians, nutritionists and others is wonderful to see.

We personally know of crippled children who have been helped. We have seen farm workers understand more about health care and their need for personal participation. We have seen fathers, crippled with a multiplicity of ailments, once again supporting their families.

We believe in the Migrant Health Act. We believe, as do the migrants, in those who administer the work. We believe the money is carefully and effectively used and that it should be increased.

We believe in specialized staff specifically under this funding. We believe that $12 for the care of one farm worker per year is very little compared with the general public average of $250 per year per person. It would be an insult to ask if you believe $12 is too much for a life.

But we would ask that the act be extended and funds increased so that more $12 units could reach the rest of the migrants now unreached, and even extend to all seasonal farm workers.

Thank you, Mr. Chairman.

The CHAIRMAN. I congratulate you on your statement. It is a very fine statement.

I think one of the most powerful things you have stated is the necessity that we have a separate categorical unit, with a separately trained staff and administration.

I agree with you that when all of this is put into one lump, the people with the means to hire people to come up here to lobby, will be here.

When you get into that pool, the people who are there all the time will cut the pie, to use a slang term.

I was with a staff officer in World War II. There was one man who wanted to go to Washington. I said, "I am a mere civilian but you are a Regular Army officer. It looks like to me if you want to be promoted, you would want this field service in the record. You have to have this on your record to be a general."

I had been a judge and he turned to me and said, "Judge, if you want part of the gravy, you got to be close enough to reach the bowl with the ladle. I have been in the Army since you graduated from the Academy, and if you are not close enough to reach that gravy bowl ladle you finally will be passed by."

He did get back to Washington, became a two-star general and head of his division before he retired. Now he holds a civilian job, I am glad to say, in an educational endeavor where he is making a real contribution.

His was a Special Service group and he became Chief of the Special Service.

I am afraid these people will not be able to reach the gravy bowl ladle.

I am shocked to hear Miss Johnston's great efforts have been reduced, by reducing the people from 22 to one.

I would like to explore this matter of seasonal workers. I had the idea that somewhere in your statement you were using the words "seasonal" and "migratory workers" interchangeably.

However, I am forced to leave the committee at this time.

I thank all of you for your presentations.

The committee will stand in recess until 10 o'clock in the morning when we will resume hearings on this same bill.

(Whereupon, at 12:40 p.m., the subcommittee recessed, to reconvene at 10 a.m., Wednesday, October 22, 1969.)

MIGRANT HEALTH SERVICES

WEDNESDAY, OCTOBER 22, 1969

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 4232, New Senate Office Building, Senator Walter F. Mondale presiding pro tempore.

Present: Senators Mondale and Dominick.

Committee staff members present: John S. Forsythe, general counsel; James Babin, professional staff member to the subcommittee; and Jay B. Cutler, Minority counsel to the subcommittee.

Senator MONDALE. The Subcommittee on Health will come to order. Senator Yarborough, chairman of this health subcommittee, was unexpectedly called away on important business, and I have agreed to carry forth with the hearings on this very vital piece of legislation that will extend the Migrant Health Act for 5 years with substantially increased appropriation authorizations.

Our first witness was unable to be here, and I ask that there appear in the record at this point a telegram from him indicating the reason.

(The telegram follows:)

CHICAGO, ILL., *October 17, 1969.*

Hon. WALTER MONDALE,
U.S. Senator, Senate Office Building,
Washington, D.C.:

As health officer in Michigan personally involved in migrant health services for over four years, I can heartily testify to the need for continuance of Migrant Health Act.

Despite efforts in comprehensive health planning, the distinct health problems of the agricultural migrant necessitate continuance of legislation until such time that migrant health services can truly be programed into comprehensive health plans.

Vital role that migrants play in our total Nation's economy certainly makes the health of the migrant a legitimate concern of our Nation's lawmakers.

ROBERT P. LOCEY, *Director,*
Berrien County Health Department, St. Joseph, Mich.

Senator MONDALE. Our next witness this morning is Miss Faustina Solis, project director of the Farm Workers' Health Service, California State Department of Public Health, Berkeley, Calif. Miss Solis, will you please come to the witness table.

Miss SOLIS. Yes.

Senator MONDALE. Do you have a prepared statement?

Miss SOLIS. Yes, sir.

Senator MONDALE. You may proceed as you wish.

STATEMENT OF FAUSTINA SOLIS, PROJECT DIRECTOR OF THE FARM WORKERS, HEALTH SERVICE, CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH, BERKELEY, CALIF.

Miss SOLIS. Mr. Chairman and members of the committee: It is a distinct pleasure and a welcomed opportunity to appear before you concerning proposed legislation to extend the Migrant Health Act due to expire at the termination of the current fiscal year, June 1970.

I am here to lend strong support to the extension of this act since my work makes me gravely aware of the serious implications which the discontinuance of this legislation would mean to the million and more migrant workers and their families in this country.

Throughout the Nation, State, and local agencies receiving migrant health grants can document undoubtedly the breadth of health benefits that have been derived by migrants through the provision of personal and environmental health services.

Mr. Chairman, I would like to depart from time to time from the written statement because I believe there are some clarifications that need to be made and elaborations regarding the programs that they have developed.

As I was coming here on the plane from California, I was thinking about the time when you did not have a Migrant Health Act and about the many kinds of circumstances and situations which developed out of our unwillingness to look at the invisible problems.

Though strides have been made in improving some of the living and working conditions of the migratory population, we cannot disregard the fact that frequently they still reside in dilapidated and substandard dwellings or, in the absence of shelter, huddle in the orchards, riverbanks, or makeshift shelters.

They may be living in areas without running water or with unsafe water supply systems, under conditions that breed disease and life hazards. Their type of employment rates high in occupational disease and injuries in California. Their health status, though somewhat improved, continues to reflect untreated chronic diseases, malnutrition, absence of adequate prenatal care and postnatal care.

Personal health care consists primarily of medical care for acute conditions and preventive services when these are available and accessible to them. Migrants tolerate gross dental problems because these services are generally beyond their economic means and even with migrant health funds, only emergency dental care, usually extractions, can be offered as a result of limited funding.

Continuity of medical care cannot be assured, since hospitalization for illness or elective surgery is not available. The migrant's uncertain mobile patterns, his social, economic, and geographic isolation constitute major detriments to his attainment of crucial health services.

There are several attachments to this testimony, and I do not wish to prolong my time on this by reading all of the testimony, but I would like to concentrate in areas.

Senator MONDALE. What we will do will be include your full statement in the record as though read, and you can extrapolate from it as you wish.

Miss SOLIS. Yes. I would like to, for example, point out that without the migrant health program in California, we would have no medical services available to the population in the rural areas.

I might also point out that the plight of the migratory worker really mirrors the plight of the resident rural poor.

What are the deterrents to the continuation of migrant health services—should there be no extension of the Migrant Health Act?

A recommendation that has been made for at least the past 2 years has been to incorporate migrant health services in the implementation of Public Law 89–749, the comprehensive health planning legislation. I suggest that we look at the implementation progress of this legislation in the States and in the regions.

What kinds of programs other than special and specific planning or demonstration programs are really in full swing? In fact, are the council bodies organized and have the community needs been assessed realistically? Who is or will be the spokesman for the rural poor, much less the migrant in those councils? Is the migrant, who constitutes a minor percentage of the population, going to be afforded priority consideration?

Maybe I just tend to be pessimistic but progress thus far does not seem to insure comprehensive care for the migrant for some years to come. His lack of voting power, his mobility, his social and economic isolation, plus his being nonvocal, automatically reduces his competitive power for services.

Let us, then, consider another suggested alternative, title XIX. Title XIX is a vendor payment system; it is not a health care system. It does not provide resources for care; it pays only for care provided, if that happens to be available. It is a program that attempts to do away with segregated care of the poor or medically indigent, allowing the patient his choice of physician, but in the end the physician has his choice of whether he can accept another patient.

In areas where there is shortage and maldistribution of physican manpower, health care does not become that readily available. In addition, the seasonal employment and unemployment status causes a constant turmoil in procedures to establish certifiability of a family and only when that family can be linked into a welfare category.

In recent months, due to alterations in the reimbursement to county hospitals, under title XIX formula, for example, outpatient care in most county hospitals in rural California have affected a drastic increase in rates per outpatient visit, which currently range from $7 to $20 per visit. The outpatient clinics have always been used by the medically indigent when their resources were limited or care was needed on emergency basis.

Even though the patient may undergo a means test to determine his liability for payment, he would rather not use the service than be plagued by bills that he cannot pay and feels obligated to pay.

Supportive services in the form of preventive services and followup care are not inherent nor assured as a part of health care in title XIX as practiced.

Consideration has also been given periodically to prepaid health insurance for this population. Attempts thus far have been unsuccess-

ful due to the problem of interstate mobility, undetermined labor itineraries, seasonal employment, and the undetermined actuarial costs to implement such a program.

All of these alternatives are not without merit; but in the present state of health care, we foresee the need for continuation of special appropriations for migrant health beyond the next 2 years. I say "beyond the next 2 years" because it has been a problem to administer a program on a State level as well as on a local level with the kind of piecemeal grant periods that have characterized the migrant health program.

I would also like to call your attention to the fact that we are extremely proud of what has been done in California and in other States with the cooperation that has been afforded us by such organizations as State and local medical societies and other voluntary and public agencies. Due to the migrant health program, other social and educational programs have developed in the State. We still feel, however, that in terms of personal and environmental health care, we are barely beginning to make any kind of progress.

You have, as an attachment here, a great deal in regard to ranking in order of disease, number of patients, the increases that are reflected in attendance, the fact that patients are referring themselves rather than being referred by professional staff.

On the other hand, we are still tabulating primary conditions. We still do not have a complete health profile of the migrant and his family because we do not have the resources nor the type of program that would provide this.

The State of California initiated programs for migratory workers in 1961 by State legislation. With the enactment of Federal legislation, we have been able to increase that program to 22 seasonal and year-around projects. This does not mean we are covering the State, for there are at least five counties that do not have programs for migrant health and they have a significant number of migrants.

Again, I would like to reiterate that the bill that has been introduced, S. 2660, with its extension of 5 years, is one which we would strongly support, even knowing that the appropriation recommended for comprehensive care would not be sufficient.

This concludes my testimony.

(The prepared statement of Miss Solis may be found on p. 101.)

Senator MONDALE. Thank you very much for your excellent statement. I gather from your testimony that if the special Migrant Health Service program is abolished and incorporated into other programs, like medicaid, that the migrant problem would not receive much help, that it will receive much less help than it is receiving today. Would that be accurate?

Miss SOLIS. That would be my impression. Not only that, they would be receiving less help because in most counties and States the migrant does not have priority status. I mean if you are looking at the total

population, you are going to provide programs that serve a greater percentage of the population, and those that are less in number and have less voting power would necessarily not have priority rating.

On the other hand, in terms of the kind of comprehensive care that has been offered in various migrant health projects, it is not just a one-shot deal in terms of an acute condition such as most people go now for medicaid, but it is the whole complement of preventive and other services which I think the migrant health program has been able to sustain in the various States in the country.

Senator MONDALE. How many years have you been engaged in your present position?

Miss SOLIS. I began to work with the program in 1963 as a social worker consultant. Currently, I am director of this program.

Senator MONDALE. How much is being spent federally and locally to provide health for migrant workers in California?

Miss SOLIS. I am going to use the current fiscal year figures. For the current fiscal year, Federal grant appropriations to the State is approximately $1.5 million. The State appropriates $100,000 just for local projects, but in addition to that, it appropriates funds for three positions, and administrative costs on the State level.

Senator MONDALE. Most of the money is Federal?

Miss SOLIS. Yes, very definitely, most of the money is Federal. The local people contribute in kind through services, maybe up to 50 percent, to the migrants in their total county.

Senator MONDALE. Does the program require local approval or local option? For example, must you first receive the approval of the county board or some other local officials to obtain a health program, or can you go around them and set up your own program?

Miss SOLIS. Well, if you are setting up a program that is under the jurisdiction of the county board of supervisors such as a county health department, it would have to be approved by the board of supervisors since they must administer the funds, and in our State the funds are paid on a reimbursement basis through contracts with the State health department.

Senator MONDALE. Do you have any counties in which you want programs with which the county board won't go along?

Miss SOLIS. We did have that situation, not only county board of supervisors but, you see, if you are involved with personal health care, you must also have the endorsement of the local county medical societies in order to be able to carry on a program, and in some instances this was not possible.

Senator MONDALE. In other words, you have to have your local medical society on your side?

Miss SOLIS. Yes.

Senator MONDALE. Otherwise you are not going to get the professional help you need?

Miss SOLIS. Yes; we do need that additional manpower, however, I think the attitude in California has changed considerably, and we have had increasingly more support from local medical societies. There are four local projects administered by county medical societies in California currently.

Senator MONDALE. Are there any major counties, major from the standpoint of large farmworker concentration, in which you do not have a farmworker health program?

Miss SOLIS. Yes; Tulare County is one.

Senator MONDALE. Does that include the city of Delano?

Miss SOLIS. Delano is on the border of Kern and Tulare.

Senator MONDALE. You called for a 5-year extension?

Miss SOLIS. Yes.

Senator MONDALE. I don't know that we will be able to do it, but wouldn't it be preferable if this would be made a permanent program? If you urge people to join the program on the ground it is going to be around, and if one wanted to plan his career in this field, wouldn't permanence be a great help?

Miss SOLIS. Well, you know, one of my reactions to this is that I am really concerned about what is happening to the total rural poor population. We really have not looked at the needs of the rural poor in terms of health, and it is very difficult sometimes to see the same kinds of problems that exist in the resident rural poor that we have for the migrants; but administratively or in practice or legally, you say, "Well, a resident of a county still has access to programs for medical indigents." Well, whether that is so in practice is another thing.

But I believe that the future does mean that certain specialized programs will continue to exist in order to take care of the special kinds of programs that rural people do have in relation to obtaining meaningful health care services.

Senator MONDALE. In your experience have you found undernourished or malnourished farmworker children?

Miss SOLIS. Yes. Malnutrition, you know, is much more than undernourishment. This is where the problem areas are, because our data show this, and unless you are doing something more complete than just examinations and are doing laboratory screenings, many of the conditions that are prevalent in the population cannot be determined.

We still have 25 to 40 percent of children with anemia, for example, but anemias also run high in the adult population.

Senator MONDALE. Do you think anemia is related, principally, to malnutrition?

Miss SOLIS. In many instances it is an iron deficiency problem.

Senator MONDALE. What about pesticides? Do you get much evidence that farmworkers are exposed to pesticides?

Miss SOLIS. Yes. I had mentioned earlier that—well, no, I had not mentioned it verbally, but I have in this written testimony, a great concern about occupational disease and injuries in this population.

The department of public health has been doing studies on pesticide poisoning.

Senator MONDALE. In California?

Miss SOLIS. Yes, particularly as relates to the organophosphate pesticides.

Senator MONDALE. Have you seen those studies?

Miss SOLIS. Yes.

Senator MONDALE. Have you participated in them?

Miss SOLIS. Yes. You see, we had to go out in the peach orchards early in 1964, when workers had been exposed to parathion, to measure the levels of cholinesterase in the blood cholesterol. This is another area where we couldn't possibly do the work without additional resources, and we were hoping that cholinesterase testing could be undertaken routinely just as much as tuberculosis screening is done in clinics. I have an article with me on periodic determination of blood cholinesterase.

Senator MONDALE. We will get it in the record if you please.

(The information referred to follows:)

PERIODIC DETERMINATION OF BLOOD CHOLINESTERASE LEVELS AS A MEANS FOR PREVENTING ORGANIC PHOSPHATE POISONING

Cholinesterase (CHE) is an enzyme found in many tissues including blood. Analytical methods for measuring CHE content of blood are relatively simple, accurate, and inexpensive. Moreover, only a small specimen of blood is required for the analysis. As a result of these factors the amount of CHE present in human blood is well known.

Organophosphate pesticides, such as parathion, exert their harmful effects by inactivating CHE at certain sites in the nervous system where its presence is vital to normal function. CHE in the circulating blood serves to protect the nervous system from organophosphate poisons which have entered the body. It does this by "binding" the pesticide, thus prohibiting it from reaching and inactivating nervous system cholinesterase. In this process, blood CHE is, itself, inactivated, but since it serves no apparent physiological function and will regenerate itself slowly, the only result of this inactivation is a measurable decrease in the blood content of active CHE.

If each day, sufficient quantities of organophosphate pesticides are absorbed, blood CHE levels drop slowly until ultimately there is not enough CHE remaining to "bind" the intruding toxin, which is then free to enter the nervous system and produce overt poisoning.

A properly designed program of CHE testing can serve to identify the worker with low blood CHE before he becomes overtly ill. He can then be warned to take more stringent precautions to protect himself or advised to avoid contact with organophosphate poisons altogether until his blood CHE regenerates to a safe level, as determined by subsequent blood CHE analyses.

Senator MONDALE. Is it your opinion that farmworkers are exposed to serious hazards of pesticides?

Miss SOLIS. Yes. The other area, that has not even been touched upon is, for example, how much exposure is there in children? We looked at adults but never looked at children who are in the field even for a period of 3 or 4 months. This is the total problem of occupational disease in children which has not been given any consideration thus far in our work.

Senator MONDALE. I am often astonished by how this remarkable system that we call American medicine—and it is a medical system—nevertheless, still basically stops at the shoreline of where the money is

The migrant worker, the farmworker, the aged, the politically impotent, the mentally ill, people whose only hope depends upon public assistance, without more, find themselves with usually inadequate, or often no, care at all and often a medical delivery system which is insulting. For instance, you get a vaccination shot together with an insult. The extent to which American medicines does not train its doctors to understand and cope with the problems found among those who can't afford to pay a fee for services, particularly a farmworker, is shocking.

To take a classical example, I have had doctors tell me they really were not trained to identify pesticide poisoning, yet it is not unlikely that a doctor will declare a farmworker totally healthy, when one more shot of parathion will kill him because it is carried in his system.

I had a doctor in a McAllen, Tex., mobile unit, which is an inadequate program, tell me that he was not trained in medical school to identify malnutrition. He had to figure that out himself.

Migrant health is one of the few programs in which we try to bring health service to, ironically, the hardest working, and yet poorest, sector of American society.

Miss Solis. Yes. When you have a number of multiple variables which would produce multiple conditions, yet I don't know and maybe other witnesses here will have it, for example, but what is the average time that a patient is seen in a migrant health clinic? I imagine it ranges anywhere from 3 to 5 minutes, and do you establish this kind of diagnosis in that period of time or any other serious diagnosis?

Also to what extent is quality care going to be provided, whatever is defined as "quality care"? Are you going to provide it when you are seeing 50 and 60 patients a night and working until 1 or 2 o'clock in the morning and you have no laboratory facilities with which to work? These are the problems.

I think you have hit on an extremely important problem; and that is, that money does not buy attitudes and concern for commitment.

Maybe it does buy a kind of commitment in terms of being paid for a service, but as far as the worker is concerned, you can have all of the staff and unless there is that quality of an atmosphere which provides a therapeutic experience for the patient beyond alleviating his pain, it is a serious problem.

Senator Mondale. Thank you very much for your excellent testimony. I wish we could go on longer, but we have a full panel of witnesses this morning. Thank you so much.

Miss Solis. If it is all right, I will leave this occupational disease pamphlet.

Senator Mondale. Very well; I appreciate that, and we will include that in the files of the subcommittee. Thank you very much.

Senator Mondale. Our next witness is Sister Mary Michaeleen, Holy Cross Sister, Denver, Colo., accompanied by Sister Mary Maurita, Sister of Mercy, Bethesda, Md., and both are in the Migrant Apostolate Council.

Sister Mary Michaeleen is the executive director, and Sister Mary Maurita is secretary for the council.

We are very glad to have you here this morning. Please proceed.

STATEMENT OF SISTER MARY MICHAELEEN, C.S.C., REGIONAL SUPERIOR FOR HOLY CROSS HOSPITALS OF THE UNITED STATES AND EXECUTIVE DIRECTOR OF THE MIGRANT APOSTOLATE COUNCIL OF THE MAJOR SUPERIORS OF WOMEN OF THE U.S.; ACCOMPANIED BY SISTER MARY MAURITA, R.S.M., SECRETARY FOR THE MIGRANT APOSTOLATE COUNCIL

Sister Mary MICHALEEN. I am Sister Mary Michaeleen, Sister of the Holy Cross. I am presently in Denver, Colo., and am responsible for our own hospitals throughout the country. I am also here as the executive director of the National Migrant Workers Council of the Conference of Major Superiors of the United States.

Sister Mary Maurita and I are here today to tell you a little bit about our own involvement and our plans to support this bill of Senator Yarborough; S. 2660. We strongly support this bill and its extension for 5 years, with adequate appropriations to meet the health needs of migrant workers.

Today there are about 405 religious communities with Catholic Sisters in the United States. We have an active membership of 160,000 professionally prepared women in the fields of health, education, and social service. Of this number, 13,000 of the Sisters are serving in health and related health service areas; 11,000 are giving direct services; and over 2,000 are in administrative positions. Nearly 5,000 Sisters are serving on the staffs of social service agencies or involved with welfare programs. We know now that there are about 200 Sisters who are involved in an uncoordinated, fragmentary manner in work with the migrants.

As some of you may know, the Catholic Sisters have a long tradition of helping the poor and especially of going in where the greatest need is for these people. For example, in the migrant farmworker area, Mother Francis X. Cabrini oriented her order to establish orphanages and schools and hospitals to help the Italian immigrants to the United States who became migrant farmworkers during the years between 1892 and 1921. Many of our Sisters throughout the years have continued this service.

So I guess it was because of our involvement over the years that it was natural that a representative of the Conference of Major Superiors of Women in the United States be invited, along with representatives of nine other religious organizations and the American Hospital Association, to a meeting at the Smithsonian Institution in Washington, D.C., by the migrant health staff of the U.S. Public Health Service in June 1968.

It was at this meeting that we were given the broad outlines of the needs of the estimated 1 million migratory farmworkers in the United States. At this time we were told about the need for 4,000 more part-time physicians, 920 more family health clinics, and 667 more hospitals being spelled out as necessary to supplement the care that was already being provided.

These were provided in 117 project areas by 1,000 physicians, 230 family health clinics, and 166 hospitals that were working together under the Migrant Health Act to establish and maintain health services for an estimated 300,000 of the Nation's total migratory farmworkers.

We were also told at that meeting that there were four hospitals doing remarkable work in organizing health services that were specifically attuned to the needs of the migrants. It was reported in total there were more than 4,000 hospitals located within or adjoining migrant crop counties. However, we did find out that only 750 of these 4,000 hospitals were sufficiently well organized for coordination to meet the health needs for the uncared-for migrant farmworkers and their families.

These hospitals were voluntary church-related hospitals sponsored by 14 denominations; and nine were Latter-day Saints of Jesus Christ hospitals; 23 were Jewish hospitals; 272 were Protestant hospitals; and 448 were Catholic hospitals.

We were also advised of the need to expand the work of the 20 Catholic hospitals and the 11 Protestant hospitals that were then serving the migrants, especially to coordinate our efforts and to intensify interest in the migrants' needs in our respective religious communities.

Through this meeting, we have had ongoing contacts with certain members of the staff of the Health Action Branch and the migrant and rural health program of the U.S. Public Health Service. It is because of this that the Conference of Major Superiors became interested in the 1 million farmworkers in this country.

At our annual conference in September 1968 we devoted a session of our program to the presentation of the health needs of migrants and examples of workable currently operating solutions to their problems by a panel of nine members that included some of our own Sisters and lay people as well as representatives of the U.S. Public Health Service.

This program really created a great deal of interest among the Major Superiors of Women in the United States and, as a result, in February 1969 the national executive committee set up a special ad hoc committee for this purpose. By June 1969 this committee had become a National Interim Council for Migrant Farm Workers, consisting of a national chairman; an executive director, which position I fill, and six regional directors.

We held our first meeting of this National Interim Council for the Migrant Farm Workers in June 1969 at St. Paul, Minn., and held it in conjunction with the Catholic Hospital Association's annual meeting.

Senator MONDALE. Isn't it remarkable how all good things start in Minnesota?

Sister Mary MICHAELEEN. I had to bring that in, Senator.

Following this presentation, we did come up with three conclusions that we think are very important:

First, we wanted to identify during the coming summer months the areas of services to which our Sisters might address themselves in health, education, and welfare. As I mentioned earlier, we have several hundred Sisters now involved in this work but it is not coordinated.

Secondly, we saw the need to prepare a tentative budget of expenses for travel, lodging, correspondence, telephone calls, et cetera.

Third is the need to make recommendations to the Conference of Major Superiors about future involvement of religious in in-depth service to the migrants.

The general objectives that we identified at this time included, first of all, greater collaboration and cooperation with already existing migrant health projects organized services.

Second is supplementation of existing programs with professional personnel and staff from the religious orders on either a part- or full-time basis, financed by voluntarily contributed services or on a salaried basis financed by private or public means during the seasons when migrants are now in the areas.

Third, making available additional health resources under the jurisdiction of the Sisters in the form of hospitals, outpatient clinics, mobile units and health teams of physicians, nurses, and other related health care. These are so needed, and I think anyone who has gone into these camps has seen the health needs and would agree to this.

Fourth is the creation of an awareness of health needs of migrants through dialog with local citizens, growers, social, welfare, and health and education agencies.

Fifth is possible extension of existing preventive health aspects of care to a greater number of migrants. I have visited several of the Sisters who are now working in camps both on a full- and part-time basis. When you talk about preventive health education, I remember a young mother 20 years old who needed to have all of her teeth extracted because of improper dental care and basically a lack of health education.

Sixth is the utilization of a comprehensive approach to health in an attempt to reduce acute and emergency hospitalization.

Seventh is a better system of coordinating services to provide continuity in primary and comprehensive care.

After this meeting of the Catholic Hospital Association, we had an interdisciplinary session during the convention, to allow for the C.M.S.W. National Interim Migrant Farm Workers Council a 2-hour panel to present the needs of the migrant health worker.

At this time there were 250 hospital personnel present, and following the presentation 100 responded and said they would be willing to help the migrants in their area.

After this we corresponded with all of the Catholic hospitals in the United States and got a very fine return in terms of helping the migrants in their particular community.

The United States Catholic Conference Department of Health Affairs has provided staff services to our National Migrant Worker Council, as has the U.S.C.C. Department of Migration and Relief Services. The nonprofit Center for Applied Research to the Apostolate, with headquarters here, has encouraged our council with its cooperation.

Before I turn the presentation over to Sister Mary Maurita, I would like to complete the historical record by telling you that the interim council made its report at the annual assembly September 21, and on September 22, 1969, the National Executive Committee of the Conference of Major Superiors of Women removed the word "interim" from our national council name and assured us that we have the official backing of the C.M.S.W. and have approved also a work design study that would ge done by us and will activate willing Sisters as soon as they can be assimilated into service of the migrants.

This is the research study we think needs to be done in order to coordinate the effort now being made by the sisters throughout the United States to see what the needs are and some of the unmet needs.

Now sister will tell you what has been accomplished by the regional directors during the summer months and the findings that were presented at the second meeting of the C.M.S.W. which was held in September in St. Louis.

Senator MONDALE. Sister Mary Maurita, please proceed.

Sister Mary MAURITA. Thank you. I am Sister Mary Maurita, Sister of Mercy from Bethesda, Md., and my interest in the migrant which has extended over a period of approximately 3 years is twofold.

I am serving presently as secretary of the Migrant Workers Council and am also serving as director of the Eastern Region of the Conference of Major Superiors of Religious Women, which extends along the eastern seaboard of the United States. It includes approximately 148,000 migrants in 57 Catholic hospitals in the area.

My professional background is that of a health professional, having been prepared in both nursing education and holding a master's in hospital administration, and I am presently serving as coordinator of our hospitals which are sponsored by our own religious communities extending over 26 States in the country.

As Sister Mary Michaeleen pointed out, I will try to follow, in essence, the text, but I would like to digress.

Senator MONDALE. What we will do is include the testimony as written, and you may make any comments you wish. I have read it, but you can proceed in any way you wish.

Sister Mary MAURITA. Thank you very much, Senator. First of all, I would like to call your attention to the two maps. As part of our study we, in collaboration with the U.S. Public Health Service, prepared two maps. The one on your far left and my right is a map which points out in colors the locations in the United States where migrant services are available, through the use of red, green, and yellow colors, and superimposed on the map are gold pins which represent the location of the 815 Catholic hospitals in the United States; and the white pins represent the other denominational hospitals, which are 272 in number; and the dark blue pins represent the Jewish hospitals, which represent 23; and there are nine in red, which represent the Latter-day hospitals located primarily in the States of Idaho and Utah.

Senator MONDALE. Sister, how fully do the Catholic hospitals located in migrant areas participate with migrants? Is that a spotty program? Some of them, I assume, are deeply involved, and others are not?

Sister Mary MAURITA. Senator, it is a very limited program at this time. As the sister brought out in the overall presentation, approximately 20 were intimately involved throughout the country. We feel there are 340 other, additional Catholic hospitals located in migrant counties or in the regions where migrants are located that could also become involved.

Senator MONDALE. Why aren't they? Is it a matter of money, or interest?

Sister Mary MAURITA. First, we have to call this to their attention; and second, we have to explore with them ways in which they could become involved; and third, some hospitals are providing acute hos-

pitalization which is, in part, reimbursed through the Migrant Health Act, up to 50 percent approximately, and the rest of it is either absorbed by the individual institution or is really written off as, let us say, a service, donation of services to the individual.

Does that answer your question?

Senator MONDALE. Yes.

Sister Mary MAURITA. Now if I may go on to the second map, which very briefly shows the other related or health-related resources available to us, you will notice that the colors in gold represent the Catholic and corresponds to the location of the Catholic hospitals, and they are arranged in banks, not according to counties.

The other denominational hospital resources, health-related resources and school of nursing in the areas are indicated through the use of white dots, and the pink represents the colleges for the other denominational institutions, and the purple represents the seminaries of the other denominational groups as well as the Jewish and Latter-day Saints. These, we think, are all potential resources if we could awaken and arouse them in terms of the needs of the migrant, if they could be brought into focus in terms of providing health professionals, either on a voluntary full- or part-time basis; but what we are primarily interested in is our own Sisters and the personnel resources which we have available to us.

Now to share with you briefly the findings of our Sisters in their summer assignment as a result of the three goals that we decided upon in our Minneapolis meeting, the institution or directors of the region spent a portion of the summer by personally visiting the areas in the States where they could get to migrants or employees where they are living during that particular season of the year.

For example, one of the Sisters made an extensive tour of the State of Washington; and one of the Sisters worked with the Project "Endeavor" visited the Lower Rio Grande Valley of Texas; and another concentrated upon the State of Ohio; and two other Sisters, one of whom was myself, spent a portion of our time visiting the areas in New Jersey and lower New York State.

As a result of these findings, we can categorize them in probably four major areas. I might preface this by saying we found a great deal of good will and interest on the part of those involved in providing health services to the migrant, but we also discovered that there were barriers and difficulties and obstacles. I was interested in the question you had addressed to Miss Solis in regard to insecticide poisoning; for example, in New Jersey, when we visited one of the health clinics there, we were told that the three categories that required the greatest amount of attention and treatment in clinics as well as hospitalization fell into the categories of upper respiratory disease, gastrointestinal infections and poisoning from insecticides. These are insecticides where children imbibe these accidentally.

We also classified the psychological needs of the migrants on the one hand in regard to their feeling of isolation and alienation, and on the other hand, we discovered psychological needs on the parts of ourselves as religious women and on the part of local physicians, in terms of some apathy, a lack of knowledge, in some cases misunderstanding, and in some instances even a feeling of impatience and even hostility

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toward these persons who needed certain types of services; and of course the growers where we encountered attitudes on the part of growers which indicated both apathy and hostility.

The third category is this.

Senator MONDALE. Do you find that growers are hostile to programs that bring health care to the migrants?

Sister Mary MAURITA. In one of the site visits we made, we discovered that the growers resented the fact that other persons might be interested in even donating or providing some kind of voluntary services—and one example is: a Sister who was involved in distributing food to a needy migrant family, and the grower meeting her going to the migrant camp told her that if she was ever caught there again he would take means to prevent her from going to this camp.

Senator DOMINICK. What area was that?

Sister Mary MAURITA. This happened to be New York, but it was evidence of hostility on the part of the grower toward anyone interfering with providing for the needs of the migrant.

Under the social needs, of course, there are difficulties created through language barriers, lack of education or discontinuity of education. We discovered in one State children 12 years of age were permitted to work in the fields and, as a result, were not attending summer school which was planned for them; and then there is the other aspect of the sociological and cultural needs which include a lack of identification with the local community and with their own traditional culture or cultural patterns, as well as in the fourth category of religious needs.

The Sisters also, as a result of their identification of these needs, outlined and highlighted—which is on page 6 of the report—some of the overall health needs, the overriding need for extended outreach programs, going out into camps where the migrants live; and they even suggested that Sisters have an opportunity to go out into the camps where the migrants live, to be with them to serve as liaisons and establish a close person-to-person working relationship with them in order to help them to avail themselves of the services that were available.

They also indicated the need to be working with other members of the health professions such as physicians, social workers, and so forth. They identified the other areas that have already been mentioned this morning—dental services, family health clinics, the need for more medical services and hospital services, as well as nursing, sanitation services, health education, and teaching in regard to just simply good eating habits and the proper preparation of food.

The services required for the care of the retarded child as well as the mentally ill in some cases were lacking, and the Sisters were concerned about this. They also discovered there were some obstacles to the delivery of these needed services. One would be the distance of the hospitals from the areas where the migrant farm laborers either lived or worked.

For example, we visited one camp where a young mother was expecting her baby within 2 weeks. We asked her how she was going to get to the hospital, and she said they would be dependent upon volunteer transportation to the hospital, approximately 30 miles away.

Senator MONDALE. I am convinced that one of the factors we need for execution of the poverty programs is more help on the problem of transportation in the rural communities. I have had more health workers tell me in many cases there is unsuitable preparing of transportation services. They can't deliver the services. If you can get the food, or whatever it is, or transportation for the men to train for manpower programs.

Sister Mary MAURITA. We encountered another situation, Senator, where the youthful volunteers for transporting the migrants to the clinics helped, but this would help only at the early part of the season, for toward the end it tapers off; and as a result those who depended upon this type of transportation are really not able to meet their appointments.

Other obstacles that the Sisters encountered to providing services to migrants included the lack of physicians, who are already overburdened or in short supply or who live at distances. For example, we met a physician who traveled approximately an hour and a half from New York City to come into New Jersey to service a clinic one night a week. He was doing this as part of his, well, donation of service, as part of his experience, because he was in residency training in one of the medical centers in New York City.

The Sisters, as a result of these findings, came forth with some suggestions, and these are listed in the statement. But we would like to highlight these.

They suggested methods to overcome some of these barriers, and these were drawn from some of the models that they visited of services already in existence, but also added to this some of their own creative thinking.

The use of mobile clinic units in lieu of stationary clinics they thought should be encouraged and ordinarily this should be set up as a satellite of a hospital or a more permanent comprehensive facility which might be located farther away.

They suggested the incorporation of helicopter services where available to transport critical workers, for example, to hospitals where they could get immediate attention in order to cut down the length of hospitalization.

They suggested the use of existing structures either on a rental or donated basis rather than providing new construction or renovation of areas, and the Sisters even thought that the civilian defense hospitals which are stored in the basements of both voluntary private buildings as well as public buildings, we asked the question: Why could we not make use of some of these facilities or services available from these civilian hospitals?

The Sisters felt wherever possible we should be drawing our personnel from health care facilities that are in the area and that much more should be done to motivate and encourage this kind of participation.

We see the need and want to be involved with all of the denominations in regard to the use of health personnel. There should be greater use, we feel, of medical and dental schools as well as the schools of nursing, including schools for midwifery, which could provide training service programs for the students while they are in the process of receiving their education.

We also see as Sisters we could serve in areas of nursing, education, administration, social services, in addition to serving as aides or volunteers, even working out various programs in these particular areas to serve different migrant camp needs.

Health care programs should be combined with programs of preventive health care which include sanitation training, nutrition, education, personal hygiene, and so forth. Basic education could be provided particularly drawing upon the tremendous resources of Sisters that we would have available during particularly the summer months who are prepared in elementary and secondary education, and who could be used throughout the summer to teach both adults and children in the migrant camps.

These same Sisters could also be involved in collaborating with setting up social and cultural and recreational programs for the migrants and families. The outreach program, which would be adapted to the cultural patterns of the migrants, could use Sisters particularly who have language skills in Spanish and would understand and could communicate effectively with the migrants.

Referral programs—there is a need, well, need for personnel to really help the migrant to understand where he can go to receive service in the local community. Part of this requires the ability to speak Spanish.

Assistance could be provided to migrants in terms of counseling as to how they could potentially enter or leave the migrant stream.

There are Sisters prepared in counseling who could assist in various counseling services and serve as aids to those who are providing psychiatric care to the migrants.

We mentioned assistance to transportation. All of these are suggested solutions and, as stated in the statement, they are really not all relative to the short-term and critical need to provide basic health services, yet they would have to become a component of a properly total overall organized migrant program.

I would like to turn my portion back to Sister Mary Michaeleen, who will give you the concluding remarks of our statement.

Sister Mary MICHAELEEN. Senator, you said you have read the full statement here, so I will not go into detail on the balance of our statement to you. However, I did want to emphasize one very important point. That is, as spokesmen for the major superiors, we do represent 160,000 professionally prepared women who are now engaged in health, education, and welfare throughout the country.

As Sister Maurita mentioned, the majority of these Sisters are involved in education and many of them are free in the summer months. We do feel that working with the Government with your existing health program, we can give voluntary service part-time and full-time.

We also believe that a great deal of help can come from our hospitals. Approximately one-third of the health care today is under the auspices of Catholic Sisters. We feel that it is important for you to know what we are doing and that we support this bill wholeheartedly.

We have worked with the Government. We don't want to duplicate effort of either the Government programs or other agencies. We want to supplement and assist. With that, we bring the compassion and the preparation and dedication of the religious women of this country.

Senator MONDALE. Thank you, Sister, for a most useful statement. May I express my appreciation to the National Council for Migrant

Workers for help in this field which helps to place in perspective the remarkable contribution that is being made, and even more that could be made in the private voluntary hospitals and religious sectors in this whole field of migrant farm labor.

Senator Dominick?

Senator DOMINICK. Thank you, Mr. Chairman. Sister Michaeleen, welcome. I am sorry I was not here when you started, but it is always a pleasure to have someone from Colorado testifying before us. I have read your statement and I think it is excellent. I do want to assure you that this bill will come out of committee with little or no problems and we will be pushing it forward.

Now, as to the question on the amount of time and the amount of money involved, I don't think they are going to be substantial obstacles at all. We will solve those and get the bill out.

On the summary of related resources which you have attached to your statement, you have referred to five Catholic-sponsored health related facilities in Colorado. Would you identify them for the Record?

Sister Mary MAURITA. I don't have that with me. Sorry. I cannot identify the exact location of them. Some of them are in the area of Denver.

Sister Mary MICHAELEEN. I am familiar with one very much, because I have been in contact with this Sister regarding it. This is just an example of why we need coordination in this program if we are going to give voluntary assistance. There is one program that has a mobile clinic and the Sisters provide service for about half of a year. These Sisters go out into the camp in coordination with the local hospital and do help them in terms of the health needs of these people.

Senator DOMINICK. Where is this operating?

Sister Mary MICHAELEEN. Here again it is the Franciscan Sisters, whose Mother house is in Denver. I just heard about it recently and the Sister in charge of this region has not yet gotten as far as Denver for her evaluation. You see, we have six regional directors throughout the country.

We just started in June and one of the purposes of having a study made is to find out where the Sisters are, what work they are doing, so we can coordinate their efforts and avoid any duplication of effort. But this is an example of what we can do. This is one instance of a community that has a mobile clinic, but they can only staff it half a year, so I have been in contact with this Sister to see if at the time they are not using it in coordination with other communities we can provide a year-round service.

Senator DOMINICK. I think this is very interesting. I have found myself caught up in two situations in Colorado where doctors left areas and the people were without medical care. In the one case the only doctor was retiring. In the other he was so overworked he finally just quit and moved somewhere else where there were more doctors to help him.

I talked to Mr. Egeberg about these types of problems during hearings on his nomination. Now you can't really blame the doctors. They are absolutely swamped in the area and many times they have problems in bringing up their own family in remote areas. Dr. Egeberg was talking about the mobile idea again of getting the people from the more major institutions on a mobile basis to go into these areas and provide the service.

This is why I was particularly interested in what you were doing in this field. I think if we can get more of this moving not only at the Federal level but particularly in the voluntary levels such as you are doing, it would be of real significance in solving some of these problems.

Senator MONDALE. Will you please yield, Senator Dominick? It seems to me this is a particularly appropriate area for paraprofessional experimentation. We have 60,000 returning corpsmen each year from the service, and we waste their resources. It is wasteful that we don't use them, and it would help if we could use them, as well as extend the Catholic hospitals and other private hospitals in the remarkable work you are doing. Similarly, we must find a way of extending these highly professional people out to the field, because as you point out, farmworkers are spread all over and just reaching them and seeing them is a problem. The health problems are complicated, but they are rarely even seen.

Senator DOMINICK. That is right, but not only does nobody see them, many times, by lack of transportation or by problems in trying to get up enough courage or initiative to come in somewhere, they never get treated at all.

Senator MONDALE. The previous witness pointed out a lot of them have just learned to suffer. They just don't do anything. They just get used to being sick.

Senator DOMINICK. That is correct. Sister Maurita, I guess this would be directed to you. My interest in the migrants problems really started when I read a book called "America Is in the Heart." I don't know if you ever read it. It was about a Filipino who came over and was in a migrant camp in the West. This was many, many decades ago. It described the problems he had, the amount he suffered, and then his ability to move beyond this and become a full-fledged citizen with great pride in the country.

But I have been interested in it ever since then and as we went along it seemed to me that you could differentiate rather substantially with respect to conditions as to various areas of the country.

For example, one of the worst areas we found, at least it seems to me that the evidence indicated this, was along the east coast and particularly the northeast area where many of the blacks come in and start working. First of all, they are not used to the weather and secondly, their ability to communicate with the local population was practically nil, whereas the Rocky Mountain area, to pat ourselves on the back, was considerably better and in fact maybe the No. 1 or 2 area in the country with regard to conditions for the migrant workers.

Now, do you have any comments on this?

Sister Mary MAURITA. Senator, I am afraid I am limited in terms of total experience, because of the brief amount of time that I have been exposed to this eastern region, but when we visited the camp in New Jersey, we discovered that there were black families who had come from Mississippi, but the same families had been returning year after year.

One family, for example, had come back to the same place for a period of 11 years, but which meant they were in the migrant stream and continuing along at the same pace, not really desiring to—well, we can't say "desiring," we don't know, not really being in a position, I

guess, to better themselves to either move out of the migrant stream and do something better or they found this the most satisfactory way to earn a livelihood.

In questioning this particular family, they seemed to like what they were doing and seemed to have no particular urge to want to do anything beyond this. That is why I say I am afraid I can't answer this completely because I am not experienced; my information is very limited in this at this point.

Senator DOMINICK. You remind me of a story about a fellow who was sending his daughter to school. He came to the question about whether she was a leader and he wrote "No; she is not a leader, but she is a good follower." The family received an acceptance that said, "Marvelous, we will now have 125 leaders and one follower."

Now, we have to have some followers as well as leaders in the country, otherwise nothing gets done. Everybody has a policy decision and nobody does the problem work. It has some parallels in the Federal Government.

One other question. In your six regions that you are talking about, are they consistent with any pattern of regions that are set up by HEW?

Sister Mary MICHAELEEN. We have them set up in the same way that our Conference of Major Superiors is set up, so in working with these religious communities we can coordinate the efforts of the different communities in geographical areas. The country is geographically divided into six regions and they follow the pattern of the CMSW organization.

We also are working with the governmental HEW, regions, we are tying into that. This is one of the things we are doing right now. We have not completely organized, but have six directors and are working with the project directors in the different regions of the Government.

Senator DOMINICK. That is what I was going to suggest, because I know Dr. Egeberg is extremely interested in trying to pull together the voluntary operations in order to coordinate with the Federal effort and trying to get more people in the field.

I am delighted to hear you are working with him. If we can be of help there, let us know. Thank you, again.

(The prepared statement of Sister Mary Machaeleen follows:)

PREPARED STATEMENT OF SISTER MARY MICHAELEEN, C.S.C. EXECUTIVE DIRECTOR, THE CONFERENCE OF MAJOR SUPERIORS OF WOMEN OF THE UNITED STATES OF AMERICA NATIONAL COUNCIL FOR MIGRANT WORKERS

Mr. Chairman and Senators:

I am Sister Mary Michaeleen, C.S.C., a Sister of the Holy Cross presently serving as the regional director of the province of our order which includes nine hospitals with headquarters in Denver, Colorado. I am serving also as the Executive Director of the National Migrant Workers Council of the Conference of Major Superiors of Religious Women in the United States. Sister Maurita and I have come to tell you a little about our involvement and plans for future involvement and to support S 2660 which is sponsored by Mr. Yarborough and Messrs. Cranston, Eagleton, Hughes, Javits, Kennedy, Mondale, Murphy, Nelson, Pell, Prouty, Randolph and Mr. Williams of New Jersey.

We strongly support your bill S. 2660, senators, and its extension for five years with authorization for adequate appropriations to meet the health needs of migrant farm workers and their families.

There are 405 different religious orders with communities in this country who have an active membership of over 160,000 Sisters professionally prepared in the

areas of health, education and social service. About 13,000 of these Sisters are serving in health and related health service areas. Eleven thousand are giving direct service and over 2,000 are in administrative positions. Nearly 5,000 additional Sisters are serving on the staffs of social service agencies or involved with welfare programs. At least several hundred Sisters have been involved in a fragmentary, uncoordinated manner in work with migrant farm laborers and their families.

As some of you may know, the Catholic Sisters have long traditions of providing health care facilities and services in the nation. Virtually everyone of the foundresses of the more than 400 Religious Orders of Women represented in our Conference made a particular effort to serve the poor of her era in a special way that took into account the particular problems of the people. For example, in the migrant farm worker area, Mother Frances X. Cabrini oriented her Order to establish orphanages and schools and hospitals to help the Italian immigrants to the United States who became migrant farm workers on our lands during the years between 1892 and 1921. Many of our Sisters have continued their work with migrant farm workers when the nationalities changed from Italians to Poles to Germans and so on. The women in the Migrant Ministry of the Protestant denominations and Jewish Women of organizations affiliated with the Council of Jewish Federations and Funds and many, many other volunteer women from other organizations have similar traditions of helping the migrants help themselves.

So it was perhaps natural that a representative of the Conference of Major Superiors of Women be invited along with representatives of nine other religious organizations and the American Hospital Association to a meeting at the Smothsonian Institute in Washington, D.C. by the Migrant Health Staff of U.S. Public Health Service in June of 1968.

At that meeting we were given the broad outlines of the needs of the estimated one million migratory farm labor population in the United States. The need for 4,000 more part-time physicians, 920 more family health clinics, and 667 more hospitals was spelled out as necessary to supplement the care that was already being provided in 117 project areas by 1,000 physicians, 230 family health clinics and 166 hospitals that were working together under the aegis of the Migrant Health Act to establish and maintain health services for an estimated 300,000 of the nation's total migratory farm worker population.

We were told that there were four hospitals doing remarkable work in organizing health services that were specifically attuned to the needs of the migrants. In toto, it was reported that there were more than 4,000 hospitals located within or adjoining migrant crop counties. However, only about 750 were sufficiently well organized for concerted coordination to meet the health needs of the uncared for migrant farm worker and his family. These hospitals were voluntary church related hospitals, sponsored by 14 denominations, 9 were Latter Day Saints of Jesus Christ Hospitals; 23 were Jewish Hospitals; 272 were Protestant Hospitals; 448 were Catholic Hospitals.

We were advised of the need to expand the work of the 20 Catholic Hospitals and 11 Protestant ospitals that were then serving the migrants, to coordinate our efforts, and to intensify interests in he migrants needs in our respective religious communities.

Through this meeting and on-going contacts with certain members of the staff of the Health Action Branch and the Migrant and Rural Health program of the U.S. Public Health Service, the C.M.S.W. became interested in the 1,000,000 migrant farm worker population of our country.

One morning of the general session of the Conference of Major Superiors Annual Assembly in September, 1968 was devoted to a presentation of the health needs of migrants and examples of workable currently operating solutions to their problems by a panel of nine members that included some of our own Sisters and lay people as well as representatives of the U.S.P.H.S.

These presentations spawned a vital interest and was followed in February, 1969 by the creation by the C.M.S.W. National Executive Committee of a special Ad Hoc Committee to help migrants.

By June of 1969 this committee had become a National Interim Council for Migrant Farm Workers, consisting of a National Chairman, an Executive Director (which position I fill) and six regional directors.

The first meeting of the National Interim Council for Migrant Farm Workers was held on June 9, 1969 at St. Joseph's Hospital in St. Paul, Minnesota, in conjunction with the Catholic Hospital Association's Annual Convention which convened the following day in Minneapolis.

Three conclusions were agreed upon at the first Council meeting:

1. The need to identify during the coming summer months the areas of service to which Sisters might address themselves in health, education and welfare or social services;

2. the need to prepare a tentative budget of expenses for travel, lodging, correspondence, telephone calls, etc.;

3. the need to make recommendations to C.M.S.W. about future involvement of religious in in-depth service to the migrants.

The general objectives articulated as important in such an identification of needs included:

A. greater collaboration and cooperation with already existing migrant health project organized services;

B. supplementation of existing programs with professional personnel and staff from the religious orders on either a part-time or full-time basis, financed by voluntarily contributed services or on a salaried basis financed by private or public means during the seasons when migrants are in the areas;

C. making available additional health resources under the jurisdiction of the Sisters in the form of hospitals, out-patient clinics, mobile units and health teams of physicians, nurses and other health-related personnel;

D. the creation of an awareness of health needs of migrants through dialogue with local citizens, growers, social, welfare and health and education agencies;

E. possible extension of existing preventive health aspects of care to a greater number of migrants;

F. utilization of a comprehensive approach to health in an attempt to reduce acute and emergency hospitalization; and finally,

G. a better system of coordinating services to provide continuity in primary and comprehensive care.

The Catholic Hospital Association, lending its support, provided an afternoon interdisciplinary session during its June convention to allow C.M.S.W.'s National Interim Migrant Farm Workers Council two hours in which to tell its story to 250 administrators. More than 100 of the audience volunteered to help the Council when the meeting ended. The U.S. Catholic Conference Department of Health Affairs has provided staff services to our National Migrant Workers Council, as has the U.S.C.C. Department of Migration and Relief Services. The non-profit Center for Applied Research to the Apostolate, with headquarters here in Washington, D.C., has encouraged our Council with its cooperation.

Before I turn this presentation over to Sister Maurita, may I just complete the historical record by telling you that the Interim Council made its report to the Annual Assembly of C.M.S.W. on September 21 and on September 22, 1969 the National Executive Committee of the Conference of Major Superiors of Women Religious voted to remove the "Interim" from our National Council name so that we have the assurance of the official backing of the C.M.S.W. and are preparing now to set up a work design that will activate willing Sisters just as soon as they can be assimilated into service to the migrants.

Sister will tell you what was accomplished by the Regional Directors during the summer months and the findings that were presented at the second meeting of the National Interim Council for Migrant Workers as it met for the second time at St. Mary's Hospital in St. Louis, Missouri on September 17, 1969.

Sister Maurita will you take over now?

Thank you, Sister Michaeleen.

I am Sister Mary Maurita, R.S.M., a Sister of Mercy of the Union serving as a general councilor and hospital coordinator for our 82 acute short term general hospitals and some 20 related health facilities and 30 schools of nursing. I am a nurse and professionally trained as a hospital administrator with experience in coordinating on the provincialate and generalate levels since 1961. Presently my position is a dual one where migrants are concerned. Director of the Eastern Region and Secretary of the C.M.S.W. National Council for Migrant Workers.

Our continued involvement includes a further study in depth and proposals to religious communities in the form of recommendations for deeper involvement in a more comprehensive, organized and coordinated manner through already existing agencies.

I would like to call your attention, Senators, to the two maps we have prepared for your consideration of our interests and plans. These geographical regions include 815 Catholic Hospitals located in 40 States, and identified on this map by gold pins. The 333 Protestant Hospitals are identified by white pins. The 23 Jewish Hospitals by blue pins; and the 9 Latter Day Saints hospitals by red pins. The

shaded green, red, and yellow areas identify the location of migrants and the availability of organized health and sanitation services. You will note that there are many hospitals located in the white shaded areas of the map where there are no migrants. It is important to realize that where Catholic Hospitals are located there exist health professionals who may well decide to become involved. Presumably, this may also be equally true of the hospitals of the other denominations.

The second map shows the location by state of the other health related facilities, schools of medicine and schools of nursing, colleges and some of the seminaries, for Catholic, Jewish, Latter Day Saints and the various Protestant denominations. These institutions likewise have professionals in every category which are a substantial potential resource for service to the migrant worker and his family. Again the same color identifications of gold, white, blue and red are used as is used on the hospital map.

When the National Council met for the second time on September 17, 1969 at St. Mary's Hospital in St. Louis, Missouri, the six regional directors reported on their person research. One did her study in the state of Washington. Another in California. Another in the Lower Rio Grande Valley of Texas. One in Ohio. One in New Jersey. Another in New York. In essence their observations were as follows:

There is an overriding need for extended outreach programs, going out into the camps where migrants live with personnel who can serve as liaison to work on a close personal relationship with migrants and members of medical associations and other health related and helping organizations to make them aware of the peculiar health and personal cultural needs of the migrants, for: dental services, family health clinics, medical services, hospital services, nursing and sanitation services, health education and nutrition services, mobile health services, services for the mentally retarded. There were obstacles to the delivery of needed services. Existing emergency room facilities were overcrowded or did not provide services to migrants. Many of the physicians in migrant areas were already overburdened with work or in short supply, others were at such a distance that medical services required very difficult travel. The working hours and work location of migrants are therefore a serious barrier to obtaining even existing and available services, such as they were. Since many family members, particularly women, customarily work a full day, children had to be taken care of during off hours, ordinarily at night or on weekends.

The regional Directors suggested several methods of bringing health care to the migrant worker and his family. These were drawn both from models provided by existing forms of service as well as the thinking of the Sisters themselves:

The use of mobile clinic units in lieu of stationary clinics, should be encouraged, ordinarily as a satelite of a hospital or permanent, more comprehensive facility.

The incorporation of helicopter services is recommended instead of customary ambulance patient transport where the condition of the patient is highly critical.

The use of existing structures on a rental or donated basis is preferable rather than new construction or major renovation; school buildings, homes, even stores would be sought where adequate, using portable clinical equipment which could move from site to site easily.

Personnel and services should be drawn where possible from existing health care agencies.

Hospitals of all demoninations should be encouraged to solicit volunteers from their staff and from the local community.

Medical and Dental schools, as well as schools of nursing should be given opportunities for training-service programs, as would other institutions of related disciplines.

Religious personnel would serve in their particular area of professional competence, whether in nursing, education, administration or social services.

Health care programs should be combined with programs of preventive health care such as sanitation training, nutrition, personal hygiene and so on; these programs could be offered in cooperation with local schools and teacher organizations.

Basic education could be provided with specialized classes in English and other adult education areas, as well as teacher-aid and tutorial services by volunteers.

Outreach programs should be particularly adapted to the cultural patterns of the migrants, and could utilize Sisters with appropriate language skills and societal understanding.

Referral programs are particularly needed to introduce migrants, upon arrival, of the services of public service agencies available to them in the new community.

Assistance should be provided to those migrants who could potentially enter or leave the migrant stream with the necessary preparation.

Family counseling, spiritual counseling and psychiatric assistance should also be brought to the migrant, by identifying needs Sister volunteers or others could maximize the effectiveness of professionals in these areas.

Assistance such as transportation is required in many areas, including the attendance of church services of the migrant's choice and should be considered.

Migrants have a great need for guidance toward full participation in citizenship, every effort should be made in this direction.

These objectives are not all relative to the short term and critical need to provide basic health services, yet all could flow from properly organized migrant health systems and all seem ultimately a part of any long term solution to the overall problem of health care. As health needs are addressed, items of a lower priority could be attended within the same basic framework and facilities.

With the expression of interest in the needs of the migrants, and its developing program, the Conference of Major Superiors brings to existing federal, state and local agencies a major offer of partnership. We are a group of women with professional training and competence in health care, education and social service, and of sufficient numbers to allow for large scale involvement. Our history is one of major responsibility for health program sponsorship and administration. The knowledge and experience that Sisterhoods have acquired in several hundred years of health care activity, including founding many major programs, could now be made available for new commitment to the needs of the migrants. Changes in society are freeing Sisters from other commitments in what were previously areas of unmet need. Approximately one-third of hospital care is now provided under the auspices of Catholic Sisters. Through the co-ordinating effect of the C.M.S.W. National Migrant Council, this great personnel resource can be effectively channeled into a service program of national boundaries.

What we offer, however, is not to duplicate or otherwise compete with existing programs. On the contrary, we seek a supportive role in co-operation with all others who offer leadership and support for migrant projects. The continuation of the Migrant Health Act, the projects it sponsors, as well as all other voluntary programs is essential to the success of our efforts and we welcome an opportunity to share our goals with others, as we hope they would welcome us. We expect to volunteer for existing civic, private and government sponsored organizations, and expect to serve much as other private citizens would. Where appropriate, we could accept a leadership role within a project or assume responsibility for a component program. We believe that it is appropriate and rather necessary for the migrants themselves to have a voice in defining their needs and the type of response most effective in terms of their view of the local circumstances. It is also important to involve the community hosting the migrants in sponsorship of programs, particularly since we found that interest and support of many projects has been less than desirable. What we offer that is somewhat unique is the fact that our view of this problem is national rather than local. We will speak and serve with the benefit of a cohesive philosophy reflective of the real dimension of the migrant worker stream.

Solutions to the major health problems of the migrants are foreseeable, but only with continued hard work. We urge the Congress of the United States to continue this program, expanding it as possible, particularly as a means of encouraging greater voluntary efforts. It requires time and professional training to initiate migrant health programs. The interest and financial support of civic organizations must be cultivated and meaningful opportunities for volunteered service require considerable organizational talent in their initial stages and permanent staffing to carry on. It costs money to identify needs and lay the groundwork prerequisite to less than full time or volunteered service. In offering our services to the migrants, we must stress the appropriateness of continued federal support through the Migrant Health Act, and its extension under S. 2660. We have the compassion and professional expertise required for health programs to persons who are patients in our institutions. However, the practical, on-the-job experience needed to organize this type of program, as unique as it sometimes is, requires continued federal support.

The relative merits of particular modes of service, ways of exploring alternatives and the identification of the most effective means of implementation are

particularly within the specialized expertise of those related to the Migrant Health program of the Public Health Service. This federally produced body of competence and experience should be kept intact. Federal sponsorship has frequently acted as a major catalyst for programs by giving them a measure of permanence and community acceptance otherwise unobtainable. Voluntary groups cannot always underwrite the full responsibility for a program, although they are ready to become major participants once another organization can. Most importantly, the vast scope of the health needs of the migrant workers of the United States, today largely unmet, calls upon the federal government as well as others to continue its efforts and expand them, even with added support from the private sector.

Since migrants are not resident patients they do not fit into the normal set of community health care priorities. Their needs are for an integrated system of care which crosses state lines, whereas most programs of health care are being integrated at state and local levels. For these reasons and others, we believe that the migrant health programs of the federal government should remain readily identifiable in a fiscal sense. Migrants should not be forced to compete with other priorities and programs for the time and few funds now available from the federal government.

The Migrant Health program must be given adequate support by all of us, and sufficient time and funding for an appropriate and honestly necessary effort is provided by S. 2660. We are preparing to make a long term commitment to the migrant, the poorest of the poor. Unless the basic necessity of adequate health care is provided to the migrant workers and their families, at least at a level required by their basic dignity as human beings, we will fail these people as a nation. Only with basic health care can any man hope to enjoy his rightful share of economic security and full participation in his destiny as an American citizen. We believe the legislation under consideration by this Committee today offers the best hope of achieving these goals for the migrants and their families and strongly urge its passage. Thank you.

Senator MONDALE. Thank you, Sisters, for your excellent testimony.

Our next witnesses are Miss Cornelia Porter, assistant director of the migrant health project and Dr. John Radebaugh, director of the migrant health project who testified before this committee before.

Will you come to the witness stand?

Dr. RADEBAUGH. May I say that Miss Porter is on a plane on the way to Washington. She missed the early plane. I may be able to proceed with her written testimony.

Senator MONDALE. Very well. Are you prepared to testify then?

Dr. RADEBAUGH. Yes.

Senator MONDALE. Were you suggesting that we take the other witness out of order?

Dr. RADEBAUGH. Yes.

STATEMENT OF MRS. SETH TOMPKINS, PAST CHAIRMAN, COMMISSION ON MIGRANT LABOR, STATE OF MICHIGAN, OLD MISSION, MICH.

Senator MONDALE. Mrs. Tompkins is here. If you are prepared to testify, we will hear from Mrs. Tompkins and hopefully Miss Porter will be here shortly.

Mrs. Tompkins is past chairman, Commission on Migrant Labor, Old Mission, Mich. If you will proceed. Do you have a written statement?

Mrs. TOMPKINS. Yes.

Mr. Chairman and committee members, I am grateful for having the opportunity to appear before you today. My name is Rebecca Tompkins, a cherry grower from Old Mission, Mich. I am here to tes-

tify in favor of S. 2660, "to extend and otherwise amend certain expiring provisions of the Public Health Service Act for migrant health service." I have employed migrant workers for 29 years during which time I have managed orchards working full time in the orchards with the migrants.

Presently I serve on the migrant labor housing advisory committee within the Michigan Department of Public Health, and on the Michigan Commission of Agriculture of the Michigan Department of Agriculture. In 1966 and 1967 I served on the advisory committee on day care within the Michigan Department of Social Services, and from 1966 to 1969 I served on the agricultural labor advisory council within the Michigan Department of Labor.

I am somewhat embarrassed to relate these things, however, I feel that in that I am a grower it is important that you know the broad range of my involvement and interest and work with migrants.

In 1964 and 1965 I chaired Governor Romney's commission on migrant labor which was made up of 20 people representing migrants (three), processors (two), clergy (three), growers (four), the medical association (two), social services (four), industry (one), and labor (one).

This commission, in its report to Governor Romney in 1965, strongly recommended the encouragement and expansion of Migrant Health Act programs in the State of Michigan. As you may be aware, Michigan is traditionally conservative in its use of Federal grant programs, and although we rank third in the number of migrants employed, we were slow to recognize the merits of the Migrant Health Act. This is the courteous way of saying that there was local opposition. And opposition, incidentally, was not from growers but from the medical association.

Now, however, Michigan has 10 operational, funded projects and two approved projects that, because of lack of money, are not funded, and I have a map which I shall leave with you that shows the locations of these projects within the State within the counties.

During 1968 seven local migrant health projects provided medical, dental, nursing, and other related services to 33,355 or 63 percent of the estimated 52,071 migratory workers and their dependents housed in 1,518 camps in 12 counties of Michigan. The statewide environmental sanitation program provided services to 2,438 migrant labor camps and growers serving approximately 80,000 workers.

In comparing Michigan's 1967 and 1968 records for services rendered, 1968 shows a significant increase in all services rendered with the exception of hospitalization which shows a decrease due to the involvement of the Michigan Department of Social Services in its reimbursement program for hospital care for nonresidents.

This year, 1969, Governor Milliken appointed an in-house task force on migratory labor. In their report submitted to the Governor October 9, recommendation No. 6 says—

> The task force believes that the migrant health care centers which have been functioning in 13 counties have proven worthwhile. This program should be continued and expanded to other areas. These programs have been funded under the Federal Migrant Health Act, due to expire on June 30, 1970. The task force urges the Governor to use his influence with the President and Congress to have this program continued . . .

I asked the Governor's permission to use this report because it was just turned in to him and was not yet public.

The original Migrant Health Act—Public Law 87-692—provided for a separate, identifiable, program set up specifically to bring health services to migrant workers. Frankly, I question if the HEW reorganization has carried out congressional intent.

To provide health services and to make health services accessible are not necessarily the same thing. The program as administered by the migrant health branch of the Public Health Service gave you your money's worth. It delivered services to the target population, and I am sure you are all aware that this is a criticism of many, many federally funded programs, the money does not reach the target population. I can't say loudly or clearly enough the moneys in the migrant health program have reached the target population.

It provided medical and dental treatment, immunizations and other preventive care, nursing care, casefinding, health education, sanitation services, and, beginning in 1967, hospital care. It offered consultation in all these areas and supplied many program tools such as personal health record forms, migrant housing plans, and health education films adapted to migrant situations.

My concern is that unless the migrant health program is separately staffed and separately funded the migrant will be lost in the maze of comprehensive health care. This is not an unreasonable assumption. county health departments operate on budgets determined by their tax base. At times there are not enough dollars to provide services for the resident population. The county in which I live has a resident population approximately of 35,000. With the influx of summer residents and migrant workers this population more than doubles. In fact, in the township in which I live, the population becomes 10 times greater and the impact of this is unbelievable.

I believe it is essential to have a qualified, professional, interdisciplinary staff with expertise regarding the unique problems of migrant people and whose specific assignment is migrant health. I urge you gentlemen to consider the migrant and extend the Migrant Health Act for 5 more years.

Thank you.

Senator MONDALE. Thank you very much for your very useful testimony. Coming to us as a grower, as one who has had wide experience with migrant health problems, I am heartened by your interest in this problem. I am also heartened by your endorsement of the 5-year extension of the Migrant Health Act and particularly by your testimony that through this act special kinds of help are being made available to the migrants and farmworkers who would not otherwise receive any.

I think that is a key element of this legislation. Senator Dominick?

Senator DOMINICK. As a grower, Mrs. Tompkins, do you have a hard time getting help in the harvesting season?

Mrs. TOMPKINS. No; I do not.

Senator DOMINICK. Do you need migrant help prior to the harvesting season?

Mrs. TOMPKINS. No; not prior to the harvesting season.

Senator DOMINICK. How long do the workers come in to help out on your particular farm?

Mrs. TOMPKINS. Our harvest period where we need our major number of migrant workers varies from 3 to 5 weeks only. You see, we raise cherries and apples, but the cherry harvest varies, fluctuates. I would like to say that on our farm this year we had families who had been with us consistently for 20 years.

Senator DOMINICK. So the ones that you have, generally speaking, are people who have worked for you before, is this correct?

Mrs. TOMPKINS. To a certain extent. I am very glad that you are here today, Senator Dominick, because I wanted to answer some of the questions that you asked and this is one. You asked Dr. Dougherty yesterday if it was true that the pattern is becoming more settled.

I think the same answer applies to the question you just asked me to this, that the thing is ever changing in that the families who migrate don't know themselves many times that they are going to migrate this year until maybe a week before.

It is almost like impulsive buying at a grocery store, somebody sees somebody else going and they decide to go, too. So it is difficult to say that any of the patterns are stabilizing, because just when you think you know what is going to happen, something new happens. Although we have a core of people who have worked for us before, there are always new people.

This year, on one of our farms, we had absolutely no new people and had to turn down people who had been with us before, which I disliked very much having to do, but we are licensed for a certain number of people and you can't go beyond that and our camp was all full when they came.

Senator DOMINICK. We had a substantial amount of trouble 2 or 3 years ago, particularly in California. We were trying to persuade the Secretary of Labor to permit enough people to cross the border into California in order to harvest the crops. He refused. As a result, acres of farm after farm went unharvested, tomatoes, beans, all kinds of things simply never did get harvested.

Do you have any problems like that?

Mrs. TOMKINS. Yes, we do. This year we have not had any problems with getting a sufficient amount of labor, but the year you are speaking about, I believe was, let me see, it was 1967, fall of 1967, and I recall being in the office of the Secretary of the Department of Agriculture when I was here in October and Mrs. Jacobson, I think that she was Assistant or Under Secretary, assured me there was no problem. I went home to find 10,000 bushels of apples on the ground for lack of labor.

It is hard to communicate this particular problem and yet when you see your fruit on the ground you are pretty sure that something is wrong.

Senator DOMINICK. I sure agree with that. Do you contract yourself for the laborers, or is there a contractor who comes to you and says, "We will supply you with the necessary labor."

Mrs. TOMPKINS. We contract our own. The first Spanish-speaking people that we had came to us 20 years ago and they were working for Brooks Canning plant in Indiana, working in tomatoes and their foreman there brought a group of 10 crew leaders North to see if he could find work for them for the period between whatever they were doing in the tomatoes until they had to come back and harvest them.

So they came to us actually and this man worked for us for 14 years. We have tremendous admiration for the Spanish-speaking workers, for their integrity, for their ability, and for their family life. We think they are great.

Senator DOMINICK. In other words, what you are saying is, that you contract with crew leaders, you don't pick out the individual workers yourself?

Mrs. TOMPKINS. Well, that was the beginning, this man who was a crew leader and who had never been one before, but returned for a number of years. Now we do not have crew leaders. Individual families say, "May we come back," but it is on an individual basis.

Senator DOMINICK. Is it not a fact, though, that generally speaking, whether it is true in your case or not, that most of the hiring is done through crew leaders or contracts?

Mrs. TOMPKINS. I am not sure that this would be so. You see, it varies in the States, too. This is another point I wanted to make. It varies greatly in different States. I recall 2 or 3 years ago when the Department of Labor made a survey, well, it was soon after the enactment of the Crew Leader Registration Act they were making a survey to find out how many crew leaders they could find. Incidentally, I would like to state a kind word for crew leaders. We are so apt to think of them along in the same category as farmers that are scoundrels and exploit, but our experience has been that the majority of the crew leaders we have known have been people who have gone out of their way to take care of the workers they bring with them.

But, back to the year that the Department of Labor was making a survey of the crew leaders, they found four registered leaders on my farm but not one of them was working as a crew leader. The Department of Labor men were delighted because they had not been able to find many until then.

I think the regulations, although in many ways they are good, as far as the crew leaders are concerned, make it very difficult for any person to have the money to be able to do the things he has to do. He has insurance that he has to have and this sort of thing, and I have an unhappy feeling that perhaps they are not all as informed as they should be as to exactly what is required.

I think perhaps they go to expense beyond what they have to.

Senator DOMINICK. When these workers come to work in your orchard, are they living in a permanent camp which is set up near your farm or on your farm?

Mrs. TOMPKINS. They live on my farm.

Senator DOMINICK. Do they live in a permanent camp which you built?

Mrs. TOMPKINS. It is a camp which I built and which is licensed by the Michigan Department of Health.

Senator DOMINICK. Do you provide medical service to the people while there, or is this done through the Michigan health facility?

Mrs. TOMPKINS. In the State of Michigan, we do have workmen's compensation that provides hospital and medical care for migrant workers.

Senator DOMINICK. But what about visits to the camp?

Mrs. TOMPKINS. To the camp, well, actually we have a combination of programs. We have OEO programs and day care centers and coordination of many Federal funds in our centers and the health, or

Migrant Health Act programing is but one of a series of programs. The Migrant Health Act does provide nurses and this is one of the great services I believe they provide, in that they do have registered nurses and public health nurses who go out into the camps.

I would like to just read a little note I received, when I discovered I was coming. I didn't know until rather late and I had my family, four kids coming home for the weekend from as far as Seattle, Wash., and I was sort of short of time. I worked closely with the various groups so I called the public health nurse in Grand Traverse County who worked on the Migrant Health Act, and asked her to get me information about the 1969 program because the 1969 final program was not reported and in yet. I know you are not interested in all of these statistics or don't have time for them, but this statement I thought was important.

> Our statistics show 211 visits to emergency rooms, a reduction of 175 visits from last year. We feel this decrease shows more utilization of clinic facilities, by the migrant population.

Senator DOMINICK. Let me ask you a question. Do you have such things as sick call at the labor camps?

Mrs. TOMPKINS. At labor camps?

Senator DOMINICK. If you are in the Army, Navy or anything else, you have sick call every morning of people who are sick who can go to a clinic and either get carved up or sent back to work.

Mrs. TOMPKINS. No; but they always have me that they can tell, I am their "mother confessor" and nurse and their transportation and whatever else and I see all of the workers every morning. I usually get a report if anybody needs anything and there is always somebody that can be called on.

Senator DOMINICK. How far away are you from hospital facilities or doctors' facilities or dental care and so on?

Mrs. TOMPKINS. Fifteen miles from the hospital facilities and 7 miles from the clinic and here again there is a great variance in States. I recognize that there is a problem of transportation in California, it is tremendously more important than it is in Michigan.

Another thing I wanted to read from the nurse because she says, and because I want to point out:

> That the Migrant Health Act is bringing in and interesting other groups that were slow to become involved.

Senator DOMINICK. Well, Mrs. Tompkins, what I am trying to find out is whether the local community is involved in an outreach program so that medical facilities are made available at the camp and I gather that the answer is "No," it comes from the Migrant Health Act.

Mrs. TOMPKINS. Medical facilities are available at the camp to the extent that if I call the health department the migrant health nurse will call on them. Yesterday, if you recall, Dr. Doherty referred to the "dust" clinics. I had never heard the term before but I knew immediately what he meant. Before we had the Migrant Health Act, two times every year in the garage of our farmhouse we had migrant health clinics and we had two M.D.'s who were interested in migrants who volunteered their time. We had two R.N.'s who came out during the day and set up the tables and everything else and my husband and I scrubbed the thing out with antiseptics, with some chemicals. It was

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far from a sterile clinic, hospital-type situation, but we did have qualified M.D.'s who came to the farm and the migrant ministry furnished a Spanish-speaking interpreter.

Now, our clinic is removed 7 miles, but it is in a modern sanitary facility, but, no; we don't have sick call in the morning.

Senator DOMINICK. All right, thank you, Mrs. Tompkins. I think you have been very helpful and I admire the work you have been doing, because it is important and thank you for your testimony.

Mrs. TOMPKINS. May I tell you just one more thing, because I think it is important and it shows the involvement of the community in what the program is doing. The public health nurse reported:

> Social services in our area have definitely become more interested in the migrants as they have assumed payment of all hospital bills. The director of social services even organized a noncredit college conversational Spanish course. Many people working with the migrant programs are taking advantage of this course.

When she ended her letter, she said:

> Bye, hasta luego, I sure hope I can speak some Spanish by the time my course is over.

This is attitudes, and Miss Solis said, "You cannot buy attitudes" and I think the Migrant Health Act is developing attitudes.

Senator DOMINICK. Thank you, Mrs. Tompkins.

Mrs. TOMPKINS. Thank you.

STATEMENT OF DR. JOHN RADEBAUGH, DIRECTOR OF THE MIGRANT HEALTH PROJECT, UNIVERSITY OF ROCHESTER, ROCHESTER, N.Y.; ACCOMPANIED BY MISS CORNELIA PORTER, REGISTERED NURSE, ASSISTANT DIRECTOR OF THE MIGRANT HEALTH PROJECT, UNIVERSITY OF ROCHESTER (ALSO NURSE PRACTITIONER)

Senator DOMINICK (presiding). Now, Dr. Radebaugh and Miss Porter. Doctor, it looks like you will have to come up on your own since Miss Porter has not arrived yet.

Doctor, we have the statement of Miss Porter and this is the one you were going to give?

Dr. RADEBAUGH. Yes; we were sharing it and I will carry on and if she does arrive she will join me.

Senator DOMINICK. All right.

Dr. RADEBAUGH. Miss Cornelia Porter, nurse coordinator of the University of Rochester migrant health project and I represent experiences which have a direct bearing on Senate bill S. 2660. As one of the recipients of Migrant Health Act funding, our 6-year development is an example of an attempt to meet the needs of the seasonal worker.

I will digress and mention we are in upper New York State in the areas throughout Rochester.

What were the reasons for a program in northwestern New York State?

Located in a rich fruit and vegetable belt bordering the southern shores of Lake Ontario, the farming areas within 50 miles of Rochester employ 7,000 to 8,000 migratory farmworkers each year. Using

the crew boss system, living in isolated camps often in primitive conditions, the seasonal worker is isolated, is often an unknown person to most of the permanent inhabitants of these areas.

For example, personnel at the University of Rochester School of Medicine were unaware of migrant workers until Mrs. Naomi Chamberlain, a program coordinator, was invited to join the Monroe County Migrant Committee. After visiting camps and talking to workers, she found:

1. No local health facilities for workers;
2. Poor sanitation and housing; and
3. Lack of transportation for workers to reach existing medical programs, such as at the university medical center—20 to 30 miles away from most workers.

For example, 6 years ago one woman delivered a baby at our hospital and her husband came to meet her at the time of discharge and they walked home the 20 miles from our hospital. Five years ago Miss Chamberlain organized a volunteer program of nurses, secretaries, doctors, students, social workers, and even a psychiatrist to conduct a clinic in one of the camps. This continued for 2 years, but was inadequate in that many workers were unable to reach the clinic.

Senator Dominick. Let me interrupt there. You say they were conducting a clinic in one of the camps and many of the workers were unable to reach the clinic?

Dr. Radebaugh. Not from that camp, but other camps nearby. The clinic was available to other workers and really only supplied the needs of that one camp.

Senator Dominick. I see.

Dr. Radebaugh. Others nearby, most of them were unable to reach it. We applied 3 years ago for a small grant and this allowed expansion to two centers and the addition of a dental program. However, the demand continued to be greater than the staff could meet.

One year ago, with more funding the project expanded to a larger center 40 miles away, central to an area including over 50 migrant camps and over 2,700 seasonal workers. In addition, the program, able to obtain donations of equipment, helped supply volunteer clinics in two other counties. Thus, with our access to donations here we were able to supply other programs that were not funded.

As a result of this expansion, full care was made to family members, the complete medical program of all age groups. Last year we examined 2,000 medical patients and 1,578 dental patients and hospitalized 28 patients and examined 1,000 day-care patients. The latter was entirely a preventive program and included physical examinations, vision testing, hemoglobin, and urine testing. In two day-care centers, a dental prophylaxis program was offered, with a dentist present usually 2 to 3 days a week during the summer.

Senator Dominick. This is much more similar to my sick call comments I made earlier, I gather, which you are really providing service in the camps?

Dr. Radebaugh. We are attempting to; yes.

Senator Dominick. When you talk about the funding of these projects, is all of the funding done through the Migratory Health Act?

Dr. Radebaugh. The major portion of it is. There are other services. We have a great deal of equipment that was not supplied through the

Migrant Health Act. For example, Delco Co. was enlarging its medical department and we were able to receive some equipment from them. Another company was enlarging and we—well, people knew about us and we received donations of equipment—a fairly sizable amount.

Senator DOMINICK. What about the hospitals in Rochester, were they contributing to it?

Dr. RADEBAUGH. Our hospital had contributed a number of volunteers and one or two others have also. The hospital itself is unable to contribute services except those that are paid. I mentioned our hospital will not refuse patients, but we have a difficult time sometimes getting people on medicaid to allow for the usual payment arrangement.

Senator DOMINICK. Do you have support from the local charitable institutions such as Catholic or Protestant charities?

Dr. RADEBAUGH. No; we do not. We have no support moneywise except through the Migrant Health Act.

Senator DOMINICK. Has anybody made an effort to get that support?

Dr. RADEBAUGH. No; I purposely am behind this and should try to do that. We have not.

Senator DOMINICK. Excuse me, I interrupted. Go right ahead.

Dr. RADEBAUGH. In 1969, while examining a similar number of patients, the staff was able to achieve more continuous care with the same doctors and nurses in attendance. The same team would go out each night so people could make appointments to see the same doctors or nurses each night.

Also a number of community workers assisted and students from the University of Rochester Medical School and students from the inner city developed an active health education program. This inner city program was locally funded. So although we didn't actively go out and try to get funds, say from some of the charitable organizations, this funding did supply students who worked with us in the health education program.

A local OEO program, the Urban League and health department nurses were also active in an outreach program at clinics and in camps.

Yet, with all of this—only one-half of the seasonal workers in the project area were reached by the program. Many did not know of the facilities. Funding was inadequate to provide all of the medical supplies or equipment needed and many of the personnel continued on a volunteer status. About half of our staff are volunteers at the present time.

In spite of its development, the program falls far short of the needs of the seasonal worker. Some workers travel 40 miles to clinics—how many others cannot find transportation for that 40 miles? The program does not meet the needs of the seasonal worker.

The most glaring need that the seasonal farmer has falls under the broad umbrella of "education," specifically medical and dental education. Needless to say, an individual without a good education simply cannot cope with the complexities of life around him, and these complexities of life include our medical and dental systems.

We are a society that is concerned with prevention, prevention of everything. Yet, the concept of prevention is unknown to many seasonal workers. Maybe this attitude is related to their lack of hope, the inaccessibility of facilities, the lack of moneys, or their lack of trust.

I am sure that we all have our ideas as to why the medical and dental care of workers is curative rather than preventive. Workers need

assistance if we are someheow going to break this vicious attitudinal dilemma. For example, we see adolescents in the clinics who have never been immunized. Personally, last week, I saw a 16-year-old boy who never had been exposed to a shot of any kind as a seasonal worker.

Senator DOMINICK. Is he healthy?

Dr. RADEBAUGH. Yes. We have seen individuals who have been diabetics for several years, and have never been taught about their disease. Individuals who have not had a physical examination since infancy, parents who possess little or no knowledge of the role of the dentist except to "pull your teeth."

In an attempt to break the "emergency care only syndrome" we have utilized nurses, medical students, urban adolescents, dental hygienist, and community workers to teach in either formal or informal settings some salient factors regarding immunization, surplus foods, dental and medical care, et cetera.

As you all realize this is terribly superficial, in terms of numbers we need professional, paraprofessionals, and community people who are aware of this need and who can be utilized to teach. However, we need money to pay these individuals at least the minimum hourly wage.

The change in attitude is not going to occur rapidly. None of us can profess to be a sequel to Mary Poppins, but I feel strongly that creative people with some dedication and/or interest could begin to change attitudes if the monetary regard was commensurate with the amount of time and effort expended.

This is again getting after the volunteers that are so often relied on in this area and the fact to have really a truly effective program, you must have people who are in on some kind of full-time basis.

SPECIAL DISEASE CONTROL

I do not need to quote figures concerning the extent of tuberculosis and venereal disease that is rampant among the seasonal workers. However, there are inadequate funds available for followup or treatment. Local health agencies have been unable to supply medicines. Just recently, our local health department has had to cut back on its tuberculosis control program and stopped using its mobile unit, the unit most useful among the seasonal farmworkers, and they don't have enough money to keep it going and thus no X-ray facilities are available where needed.

CLINIC PERSONNEL AND EQUIPMENT

We desperately need additional medical and paramedical personnel who are aware of and sympathetic to the needs of the seasonal worker, and at the risk of being redundant, moneys are needed to pay personnel for these services. I shall not describe the team system that we have initiated this year that provides for continuous family oriented medical care. This kind of system is not available on a volunteer basis.

TRANSPORTATION

This is an age-old problem. How does the seasonal worker reach the specialized services that he requires? Many offices and clinics which workers have to attend have no evening hours and we cannot expect

another worker to take the time out of the field during the day to transport his fellow worker. We have attempted to surmount this problem by utilizing a VISTA worker and a local agency to assist us, but it would be a boon to our services and followup if we had a vehicle of our own. I might mention all of our programs are in the evening. None are in the daytime. These are inconveniences for the workers.

OTHER BENEFITS

Such services as medicaid, workmen's compensation, surplus foods, legal services, financial assistance, are all benefits that the worker is usually not cognizant of at all. Many times we noticed in contrast to the Michigan experience, that was just recounted, that workmen's compensation is not available to the seasonal worker. He has to have someone to mention it to him when injured on the job. We have tried to make people aware of it when they do come in with injuries and have actually utilized a local legal service agency to help them in this manner. These services, however, are sporadic because our own program, for example, cannot afford them.

Let me give you two illustrations of some of the problems.

Two weeks ago, a young seasonal farmworker woman, complaining of abdominal pain, was seen in a nearby hospital. Blood counts were taken, but no examination was performed. One week later she visited our clinic, was examined completely and found to have a serious chronic infection, which will require about 6 weeks of treatment. This could have been avoided by someone examining her at the time she sought her emergency care.

Senator DOMINICK. Is that the fault of a nearby hospital?

Dr. RADEBAUGH. Yes; well, it was the fault of the inadequate medical facilities in this particular area. We feel that this woman should have been examined. She came in with a complaint of pain.

Senator DOMINICK. Well, they went to a hospital?

Dr. RADEBAUGH. Yes.

Senator DOMINICK. Didn't they have a doctor there to examine her?

Dr. RADEBAUGH. They should have. There was no doctor who did examine.

Senator DOMINICK. If they didn't, someone ought to get on the hospital.

Dr. RADEBAUGH. Yes, this is being done, especially in the case of a second patient.

A 6-month-old baby was taken to an emergency room in a nearby hospital, where the nurse took the baby's temperature, gave a shot, and talked with a doctor by telephone. On the following day the mother thought the baby was going to die, but did not want to return to the hospital. Although she had never been to the Farm Workers Health Clinic, she heard that her baby would have a complete examination there. The pediatrician in the clinic suspected meningitis and the infant and family were immediately accompanied to the hospital by a medical student. Recovered from meningitis, the child is doing well, 2 months later. The hospital is being sued now by this family for what they felt was inadequate treatment at the time of their initial emergency.

Both of these examples illustrate that episodic or emergency room care is not enough for the seasonal farmworker—or for others living in a rural area. If the clinic were open nightly, rather than twice weekly, I will digress a minute to say we are staffing two clinics both of which are open 2 nights a week. If we were operating each night so we would provide continuous care, I think some of these problems, because we are available, would have been avoided.

Something better is needed; temporarily extension and expansion of the Migrant Health Act will stimulate improvement. We recommend rewording the Migrant Health Act to allow such coverage, not only for the seasonal farmworker, but perhaps for even the rural poor who have often recently been seasonal workers.

The illustration of the Rochester based program is an example of what can be accomplished in rural health care with outside funding. However, great gaps exist in the quality and distribution of services for seasonal workers or rural poor. The Migrant Health Act, woven into more comprehensive programs for rural poor, may accelerate efforts to improve medical care in this area.

To conclude, may we state the 1967 conclusions of the President's National Advisory Commission on Rural Poverty, in relation to the migrant farmworker.

(1) "Health services for migratory farmworkers have been almost nonexistent."

(2) "Although projects sponsored by the Migrant Health Act have improved, the health care of many migrant families, the program's impact is still extremely inadequate."

(3) "That the Migrant Health Act be renewed with sufficient funds to expand the program in terms of geographic coverage and services offered."

This would end our statement.

Senator DOMINICK. Thank you, Doctor. I appreciate this and I think it has been good testimony. As you probably know the administration has asked for $15 million this year which is a substantial increase in the amount of money that has been appropriated up to this time. I don't really think we are going to have too many problems with S. 2660, although it might not be a 5-year program, but 2 years until we get the coordinated health services better organized.

I did want to ask you one question about your verbiage in here. You refer to seasonal workers?

Dr. RADEBAUGH. Yes.

Senator DOMINICK. Yesterday we had a distinction made between a migratory farmworker and a seasonal worker. In what terms are you using the phrase "seasonal worker"?

Dr. RADEBAUGH. The worker who works in an area during a season, for instance, our season lasts from June through November, and in general we have not tried to distinguish between a migrant worker who comes up, say from Florida or a seasonal worker who may stay through in our area. We try to treat without discrimination between the two groups.

Senator DOMINICK. What proportion of the people who come in, I beg pardon, what proportion of the people that you refer to as seasonal workers are in fact from other States?

Dr. RADEBAUGH. Well, our total population—I am going to include seasonal workers and including migrant workers also, 90 percent are from other States. They come from Florida, Alabama, Mississippi, Texas, which are the primary areas and also Puerto Rico.

Senator DOMINICK. Do you have many from out of the country?

Dr. RADEBAUGH. No. We have none.

Senator DOMINICK. Do you have enough migratory farmworkers to be able to take care of the necessary work?

Dr. RADEBAUGH. Yes, there are enough farmworkers in our area to take care of us. In fact, there is an overabundance.

Senator DOMINICK. Are the camps permanent?

Dr. RADEBAUGH. Most of the camps are only open for 3 or 4 or 5 months of the year. However, there are more and more people who are settling out, are trying to stay, and will live in the camp over the winter.

For example, we have one camp near our project that has about 200 workers who have stayed through and lived on in that camp even in the winter. They are working in the canneries nearby and then do the farm picking during the summer.

Senator DOMINICK. Those camps have indoor plumbing?

Dr. RADEBAUGH. No; the majority of the camps have no indoor plumbing.

Senator DOMINICK. Do you have sanitation requirements?

Dr. RADEBAUGH. Yes; we do. But in general, in my estimation as a physician, in most of the counties nearby, the rules are not followed. In other words, by adequate inspection and enforcing the rules, I think the camps would be considerably better than they are.

Somebody alluded to New York State or northeast region having some of the most primitive conditions. I think we would echo that. I visited California and Florida and some of the Southern States along the seaboard and I believe that our area does have some of the most primitive camps.

Senator DOMINICK. Who builds these camps?

Dr. RADEBAUGH. Farmers usually, or the growers.

Senator DOMINICK. Do you know if the public health service has jurisdiction over camps of this kind?

Dr. RADEBAUGH. No; their jurisdiction is through the State health departments. They have very little power in this area. Their only influence, I know about, is through the Migrant Health Act. This has stimulated people in doing the work that they would not have otherwise. There is very little influence by the public health service camp conditions.

Senator DOMINICK. In your opinion, would Federal assistance in camp construction be helpful?

Dr. RADEBAUGH. Could you repeat the question?

Senator DOMINICK. In your opinion, would Federal funding for camp construction be helpful?

Dr. RADEBAUGH. I believe it would. There is Federal assistance already through the Farm Housing Bureau. It is not utilized very much and there also is some Federal assistance in self-help housing programs through the Bureau of Housing and Urban Development. I think if these were utilized more by interested groups, that this would certainly produce some improvement.

Senator DOMINICK. Well, I thank you, Doctor, I think you have given us very useful testimony and I congratulate you on the work you have been doing in this field. Obviously it has been of great value and of real significance in trying to improve the health conditions.

Dr. RADEBAUGH. Thank you very much, Senator.

Senator DOMINICK. Our counsel suggests there have been field hearings in Rochester by the Migratory Labor Subcommittee. Has there been any improvement in the conditions that you have noticed since those field hearings?

Dr. RADEBAUGH. The field hearings—or one of the camps which was investigated, had trailers which were old trailers that had been there for years, infested with rats, with outside plumbing. This farmer has now removed most of those trailers and in place has new ones. The pressure was cause to make some changes.

However, the county where the hearings were involved by and large still has very primitive camps. It has about 300 camps in that county and we do not have a public health service project. We have a voluntary project in that county and it has a long way to go in improving conditions.

It has the most seasonal workers in New York State in one county.

Senator DOMINICK. Thank you, Doctor, very much.

Dr. RADEBAUGH. Senator, I am going to digress a moment, if I may.

Senator DOMINICK. Sure.

Dr. RADEBAUGH. You asked about involving other groups or using other sources. I would like to mention that we have involved a Reserve, an Army Reserve outfit of about 200 personnel in a voluntary program where it has been needed, but we have been working with them closely. They are now providing voluntary services for seasonal farmworkers in Wayne County.

I think it is the only Army Reserve outfit I know of doing something of this sort. I took about a year in getting through redtape to have it done, but the people themselves feel they are doing something more than going through the dry runs of their training.

Senator DOMINICK. This is a hospital outfit?

Dr. RADEBAUGH. It is an evacuation hospital outfit.

Senator DOMINICK. Thank you, Doctor.

I order printed at this point statements of those who could not appear and other pertinent material submitted for the record.

PREPARED STATEMENT OF MARK R. KRAVITZ, EXECUTIVE DIRECTOR, THE SHADE TOBACCO GROWERS AGRICULTURAL ASSOCIATION, INC.

In accord with arrangements made by our Washington representative, Mr. Milton Plumb, I am submitting this statement on behalf of The Shade Tobacco Growers Agricultural Association to express our general support of your Bill, S. 2660, to extend and expand the Migrant Health Program. I request that this statement and the enclosure be made a part of the printed hearings which your Subcommittee is conducting on this legislation.

Our organization, whose membership as a group comprises one of the nation's largest employers of agricultural labor, strongly supports the principles of the Migrant Health Act. We also agree that there is a compelling need for the migrant health programs it makes possible to be extended and expanded, and we speak from experience.

Since 1953, entirely at its own expense, our Association has operated the only state-licensed hospital for agricultural workers in this country and, as a result, we know better than most the difficulties which presently confront

employers of farm labor as they seek to provide adequate medical and health care facilities for their workers. The growing crisis which confronts our nation with respect to adequate hospital facilities for the people in general is greatly compounded with respect to the maintenance and operation of such facilities for migrants and other seasonal agricultural workers, who lack any community roots in the areas where they are employed.

Federal aid is more necessary today than ever before for improved migant health facilities and the amount, in our opinion, needs to be increased substantially. For this reason, we note with approval that your Bill, S. 2660, will increase appropriations authorization from the present level of $15 million in fiscal year 1970 to $40 million in fiscal year 1975. In view of the great need for such services which exist today, we regard these proposed increases as not only necessary, but even excessively modest. We would prefer the larger and more rapid increase in funds for migrant health which has been proposed in House Bill, H.R. 13432, which would authorize $30 million in fiscal year 1971 and provide for subsequent annual increases of $15 million to a new total authorization of $60 million for the fiscal year ending June 30, 1973. Besides these authorizations, Congress also should provide the full funding established for the program. Although even the $15 million authorized for the last year would be inadequate to meet present needs of the program, the $8 million actually appropriated could not even begin to meet the urgent demands. We urge your Subcommittee to use its influence to obtain full funding for the migrant health program in the appropriation for the current fiscal year which is still pending.

In addition, we suggest one additional amendment which would, in our view, greatly extend the usefulness of this legislation and would permit it to meet a major need which now is going unmet. This would be the addition of the word "construction" to the various kinds of assistance to migrant health programs which the Act authorizes. There is a great need for many new facilities, such as clinics and even special agricultural workers hospitals, to be constructed in which proper services for migrants and seasonal agricultural workers can be provided, and the present law does not permit help to this end. In view of the fact that most states have recently raised their standards for nursing homes and hospitals, modernization of existing structures for such purposes usually is inadequate. Thus, while the present law makes important services to migrants available, they often cannot be instituted in the areas where they are most needed because of the lack of facilities to house them. We realize that, because the total funds for migrant health care are so limited, it may be necessary to restrict the proportion of funds which could be used for construction purposes. We believe that the Public Health Service officials who administer these funds are probably in the best position to determine the priority needs for migrant health care assistance and we, therefore, recommend that, rather than a limit on the total amount which could be used for construction, any limitation, if Congress feels one is necessary, should be in the nature of requiring matching funds. Any such restriction should apply, of course, only to construction expenditures.

The accompanying statement outlines in detail our experience in trying to maintain adequate hospital and medical services for some 22,000 migrants and seasonal agricultural workers employed by our members annually. While we now maintain what is unquestionably the highest quality medical care available to migrant workers anywhere in the country, we are greatly concerned about the future. Economic conditions in the shade tobacco industry and the soaring costs of hospital and other health facilities in general now make it impossible for us to continue these services at the level we believe our workers are entitled to have available without federal assistance. Since even the standards our Association has maintained, which have led the nation for many years, now are inadequate, the need for continued and expanded federal aid under the Migrant Health Act by other farm employers and their workers is all the more evident. This program is essential on grounds of humanity. Migratory and agricultural workers, like others, are entitled to decent hospital and medical care whenever they require it and such services are now beyond the capability of most farm employers and farm communities to provide without substantial federal help.

Besides these humane considerations, there are also sound practical reasons for continuing and expanding the migrant health programs as you propose.

Agriculture, which depends upon the availability of an adequate labor force, remains one of the mainstays of our national economy in spite of the depression which farm employers in general have experienced in recent years. Without adequate health care for its workers, agriculture would find itself unable to obtain the labor force needed to harvest our nation's crops, yet at the present time this industry's economic outlook and current depression is such that it simply cannot meet hospitalization and other health care costs out of its substandard earnings, which for many years have been far below parity.

Perhaps the most compelling reason of all why the help proposed in your Bill is essential at the minimum is that the national public interest requires it on grounds of public health. Disease knows no geographical, occupational or social boundaries. If Congress should fail to provide adequate health care for migratory and other seasonal agricultural workers, it would fail to protect our entire population as well.

We urge all members of your Subcommittee to support your Bill without reduction in the amount of funds it would authorize or other amendments, except for the authorization for aid to construction of migrant health care facilities which we respectfully request be added.

Attachment.

THE SHADE TOBACCO GROWERS AGRICULTURAL ASSOCIATION, INC.

THE AGRICULTURAL WORKERS HOSPITAL
Windsor, Connecticut

1 - HISTORY AND SPONSORSHIP

The Agricultural Workers Hospital of The Shade Tobacco Growers Agricultural Association, Inc., established in 1953, is the only state-licensed hospital for migratory farm workers in the United States. It has been financed to date entirely by members of the Association, a non-profit cooperative organization comprised of the growers of shade tobacco in the Connecticut River Valley, involving areas in both Connecticut and Massachusetts. The Association, established in 1942, serves exclusively in the areas of recruiting, contracting, transporting, feeding, housing, insuring and supervising of the farm workers employed by its grower members. Between 6,000 and 7,000 acres of shade tobacco, yielding about 10 million pounds, are planted each year. The crop, used exclusively for the outside wrappers of quality cigars, is grown entirely under cloth - and is dependent entirely upon hand labor since any bruising or other marring of the wrapper leaf destroys its commercial value. The shade tobacco industry is one of Connecticut's major agricultural enterprises with a labor force of some 12,000 seasonal day-haul workers recruited in the area and about 10,000 "migrants", or out-of-state seasonal workers. About 2,000 workers are employed by the Association and its grower members full time the year round. The Association's annual payroll totals more than $27,000,000.

The Association has been a pioneer in better labor standards for farm workers and has won both national and international acclaim as a progressive and enlightened agricultural organization. Today, its headquarters and model farm labor camp, occupying 19 acres in Windsor, Connecticut, are pointed to throughout the world as outstanding institutions in agriculture and are visited each year by agricultural leaders from all over the nation who are interested in inspecting its outstanding housing, recreational and cafeteria facilities, representing an investment of more than $3,000,000.

The Association has had a hand in drafting and securing the enactment of every regulation or law in the State of Connecticut dealing with the employment of agricultural labor. Regulations and laws which it sponsored to protect farm workers from substandard housing, transportation, sanitation and working conditions helped to give the State of Connecticut its present reputation for the best agricultural labor standards in the nation.

These and other actions by the Association have earned for it a reputation as one of the most enlightened and progressive agricultural employer groups in the entire country.

In 1953, the Association decided to create a facility which would give its migrant agricultural workers the kind of medical care needed and due them. It was the Association's theory that a centralized hospital which could be used by all of the growers would better meet the medical needs of the workers.

Accordingly, the Association established a 32-bed hospital at the Bradley Farm Labor Supply Center, located on North Street in the town of Windsor Locks, Connecticut, a

facility which was formerly the Engineering Section of Bradley Airfield during World War II. This site was selected because in 1953 the Bradley Farm Labor Supply Center was the principal labor supply center for the Association and at that time was the best facility of the Association.

A building, formerly the Officer's Lounge of the Bradley Airfield Engineering Section, was chosen to house the Agricultural Workers Hospital and was renovated at a cost to the Association of $70,000. Health Commissioner Dr. Stanley Osborne, of the Department of Health of the State of Connecticut, and the Association worked out an arrangement whereby the Agricultural Workers Hospital was licensed by the State as a general hospital. Later, it was decided to license it as a special hospital devoted to the needs of migrant agricultural labor.

II - STAFF

The staff of physicians from the inception of the hospital through 1967 was as follows:

Dr. Ettore Carniglia, Chairman
Dr. Warren Silliman, Secretary
Dr. John Kennedy
Dr. Sidney Cramer
Dr. William Pomeroy
Dr. William Bard

All but one of the original six who started with the Association in 1953 are still with the hospital. Presently five doctors constitute the medical staff and meetings are held monthly with discussions of the problems of the operation of the hospital and bettering the services to the migrant workers regularly on the agenda.

The hospital's nursing requirements are principally performed by registered nurses. During the height of the crop season, when many agricultural workers are in the area, the staff of nurses at the hospital is increased to cope with the services required by the patients as well as to meet the specified requirements of the State. The Manager of the hospital presently is Marco Maio, a registered nurse. The orderly staff of the hospital consists of three persons.

In addition to the staff nurses of the hospital, the Association provides nursing services at some 30 camps housing approximately 3,000 boys and girls 14 to 16 years old, who are recruited out of the state as part of its outstanding summer Youth Program. Camps are visited on a regular basis at least once a week to provide minor nursing services and administer medical supplies. These nurses are available on call at all times to take care of emergency cases. When hospital care is needed by participants in the Youth Program, however, city facilities are used rather than the Agricultural Workers Hospital, which administers only to adult workers.

III - NEED FOR THE HOSPITAL

The migratory labor force employed by the Association in Connecticut and Massachusetts represents approximately 90% of all migrant farm workers in this area. The farm labor operations of the Association are carried out in an area where all other hospitals are privately endowed and are unable to accept many of the cases among seasonal agricultural workers who need hospital care, i.e., mumps, chicken pox, measles and respiratory infections. The worker is away from home and minor, as well as major diseases must be treated in an institution to keep them from spreading throughout the camp area. If the worker were at home, he would be treated by a doctor and then continue his treatment and recovery at home, but since he is living in a labor camp provided by the Association or a grower, special medical attention and hospitalization is required.

A review of all the cases admitted to the hospital in the fiscal year December 1, 1967 through November 30, 1968 is representative of this problem. The attached Appendix I gives a summary of the cases taken care of by the Agricultural Workers Hospital in this period. A glance over the list of diseases and injuries treated by the hospital in the course of one fiscal year makes it evident that many could not be treated in privately endowed hospitals with the overcrowding and dire shortage of space which exists in such hospitals in the area at the present time.

Thus, the health and welfare of migrant agricultural workers in the Connecticut River Valley depends almost exclusively on the operation of the Agricultural Workers Hospital. It would be impossible for the Association to provide the migrant worker the medical care which is necessary and due him without this facility.

The Association recognizes that it would be almost impossible to operate the shade tobacco business in the Connecticut Valley without this facility.

IV - NEED FOR FEDERAL ASSISTANCE

Despite the obvious need for this facility, The Shade Tobacco Growers Agricultural Association, Inc. is finding the continued operation of the hospital almost impossible at the present time. Starting in 1958, the Association completely rebuilt its Windsor Farm Labor Supply Center and operations are now centered at this point.

The present Agricultural Workers Hospital is crowded, antiquated and outdated. The existing wooden two-story building, with narrow corridors, although sprinklered, is of questionable security for the patients. The Association spent approximately $30,000 to repair and refurbish the building in the last two years, although it merely rents the facility and may have to relinquish it at any time to military demand. Because the need for a new hospital building is obvious, the Association has purchased land next to its modern Windsor Farm Labor Supply Center and earmarked it for this purpose. Plans for a new facility were drawn by an architect and several thousand dollars spent to bring water to this site. It wanted to build a new modern hospital facility containing 30 beds but it is impossible for the Association to finance this undertaking at the present time.

Within the present year a crisis with regard to the hospital has developed. The present building no longer meets the state's regulations, and with stricter regulations effective July 1st, immediate action is required if the hospital is to continue to operate next year.

For this reason, the Association, which heretofore has financed all of its improvements and services on behalf of its migrant agricultural workers, is applying for federal help for the first time in its history. Shade tobacco, it perhaps should be noted in passing, does not receive the subsidies given to other forms of tobacco and the shade growers, accordingly, have received no federal assistance in any form up to this time.

V - AMOUNT OF FEDERAL MIGRANT HEALTH ACT FUNDS SOUGHT AND THEIR PURPOSE

To meet the immediate needs of providing improvements which will enable the Agricultural Workers Hospital to continue its essential services to the migrant workers of the Connecticut River Valley, the Association itself has made $75,000 available. It also proposes to renovate an existing housing unit at its Windsor Farm Labor Supply Center to provide a modern facility and more space for its hospital. This building, with an appraised worth of $100,000, is of cinder block, one-story construction and contains 5,700 square feet of floor space. In consultation with Connecticut State Health Department officials, the Association has worked out plans for renovating and adapting this building at a cost of $130,000.

Since such an amount exceeds the funds available to the Association, it is seeking help in the form of federal assistance under the Migrant Health Act in the total minimum amount of $50,000, of which $30,000 would be for renovation and $20,000 would be in the form of aid to improve services and other assistance. The latter would allow the Association to apply its own funds which it otherwise would have to spend for improving these services toward the cost of renovating the building to be used to house the hospital.

In seeking these funds, the Association has one primary objective - to improve and deliver more quality care to the migrant agricultural workers employed by members of the Association. It would accomplish this in three ways:

1. It would provide, through renovation of an existing facility, a modern hospital building with 30 beds and additional needed space and facilities, which would conform in all ways with the regulations of the State of Connecticut for hospital use.

2. It would increase the quality and services afforded to migrant workers through its out-patient department, which now is inadequate to the needs.

3. It would provide more comprehensive and higher quality care for in-patients.

VI - SPECIAL NEEDS OF OUT-PATIENT SERVICES

The present facilities of the hospital clearly are inadequate to meet the needs of the large number of workers requiring out-patient care. The waiting room and examining rooms are inadequate and added space must be provided for them. Moreover, at present, both in-patients and out-patients must use the same facilities and the danger of cross-contamination is greatly increased.

Plans for the renovated building call for the establishment of minimal X-ray facilities for out-patient care, requiring the installation of lead walls and ceilings in a special room for this purpose. Such facilities are badly needed since it is now necessary to send patients requiring X-ray examination to the City of Hartford, usually causing at least a full day's delay before treatment can begin. This facility would eliminate the present cost of transportation to Hartford, release an attending staff member for duty at the hospital, and reduce additional radiology expenses.

Besides lack of adequate space and necessary facilities, the hospital presently lacks an adequate staff to provide the improved services required by its out-patient department. The Association proposes, through providing better facilities, to increase the services provided by its present staff as well as to expand its services by additional staff adequate to handle the work load. Additional clerical help is urgently needed to process the records of out-patients, releasing a nurse from this duty, thereby reducing the unavoidable delays which migrant workers needing medical attention now face. These delays discourage them from returning to the hospital for future care and they thus are more likely to fail to seek medical attention for minor, but contagious, ailments because of the inability of the present staff to treat them promptly. The Association, while recognizing that additional staff is necessary, finds itself unable to finance its cost at the present time. Expenditures for direct operating salaries of the hospital, exclusive of the physicians' fees, totalled $68,000 last year, an increase of $9,000 over the previous year's wage costs.

VII - SPECIAL NEEDS OF IN-PATIENT SERVICES

Since the same nursing staff of the hospital handles both in-patient and out-patient needs, the remarks above concerning the inadequacy of the present staff with respect to out-patient care apply equally to their ability to provide top quality care to in-patients. If additional staff and better facilities are made available, the quality of in-patient care automatically will increase. The biggest need of the in-patients at the present time, however, is for a more adequate hospital building and facilities. Not only does the present wood building fail to meet even the lower State standard for nursing homes, but it is crowded and does not provide all of the facilities required for the quality of medical care which the Association wishes to provide its workers.

Assistance from the federal government also is needed to help underwrite the increasing costs of medical care for in-patients. The hospital is presently financed in part by receipts from hospitalization insurance which the Association provides its adult migrant

workers. This provides $15.00 a day per patient toward the cost of such services and the grower members of the Association make up the difference in the cost of running the Agricultural Workers Hospital through assessments. Federal assistance under the Migrant Health Act to help underwrite the rising costs of running the hospital is essential at the present time in view of the need for the Association to devote all its available funds to undertaking the extensive renovation of its hospital facilities.

VIII - BUDGET FOR REQUESTED FEDERAL AID

The minimum total of $50,000 in funds requested for the Association under the Migrant Health Act would be used as follows:

For renovation of existing building to provide improved hospital facilities so that they will meet state regulations $30,000

For additional staff to improve in-patient and out-patient care and help in underwriting costs of operating the hospital $20,000

36-746 O - 69 - 7

GERRIT KROT, President
ALBERT H. NEWFIELD, Vice-President
DAVID F. DUYS, Secretary and Treasurer

Address Correspondence to:
MARK R. KRAVITZ, Exec. Director
Box 38, Windsor, Conn. 06095

The Shade Tobacco Growers Agricultural Association, Inc.

ANNUAL REPORT AGRICULTURAL WORKERS HOSPITAL

ADMISSIONS SUBMITTED UNDER GROUP INSURANCE POLICY
December 1, 1967 - November 31, 1968

	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Total
Eye, Ear, Nose and Throat:													
Tonsillitis	1				1	1	1	2					6
Otitis Media			3	1	1	2	2	1	1	3	1		15
Conjunctivitis					2		1				1		4
Epistaxis						2	1					1	4
Pharyngitis		2				1	2	2	1	1	2	1	12
Nasopharyngitis					1		1			1	1		4
Sinusitis							2			1			3
Chronic Parotid Hypertrophy									1				1
Cervical Adenitis				1			3		1				5
Blood Dyscrasias:													
Anemia					3								3
Cardiovascular Conditions:													
Hypotension	1												1
Hypertension						1	1	1					3
Bradycardia							1						1
Varicose Veins										1			1
Phlebitis									1				1
Gastrointestinal Conditions:													
Parasites	1				2	18	5	5	2	7	3	3	46
Anal Fissure			1				1						2
Enteritis, Viral					4	1		1					6
Gastritis					2	4	2		1	3	1	2	15
Splenomegaly						1							1
Duodenal Ulcer					1	2		1	2				6
Peptic Ulcer									1		1		2

	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Total
Gastrointestinal Conditions continued-													
Enterocolitis							1						1
Appendicitis					1		1	1			1	2	6
Esophageal Stricture												2	2
Hemorrhoids								1	2	1	2		6
Gastroenteritis					1					2			3
Pararectal abscess										1			1
Endocrine Disorders:													
Diabetes Mellitus					1			2					3
Genitourinary Disorders:													
Epididymitis					2		1						3
Pyelitis						1		1					2
Renal Calculi						1		1			1		3
Cystitis								1		1	3		5
Hydrocele,										1			1
Balanitis										1			1
Dysuria											1		1
Urethritis											1		1
Urinary retention											1		1
Prostatitis					1								1
Communicable Diseases:													
Chicken Pox	10	9	2		1		1	7	5	3	5	18	61
German Measles					1	3	16	28	10	6	11	3	78
Mumps								1		1		1	3
Hepatitis								1	1				2
Syphilis, primary									1				1
Lymphopathia Venerum						1							1
Neuropsychiatric Disorders:													
Personality Disorder			1			4	5	6	5	5		1	27
Seizure Patterns			1			5	1	5	2	7	1	.3	25
Acute Anxiety Reaction				1		1	2	1	2				7
Attempted Suicide								1					1
Delerium Tremens						1	1	2					4

	Dec.	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Total
Skin Conditions:													
Tinea Versicolor					2								2
Ulcers, Leg					1		1						2
Carcinoma						2							2
Eczema								1					1
Epidermophytosis					1	1		1	2	1		1	7
Infected Sebaceous Cysts		1			2	1	-		1		1		6
Miliaria										1			1
Allergic Reaction (alcohol)											1		1
Herpes Labialis												1	1
Abscesses					2	1		1	1	3		1	9
Furuncles		1			2	1	1	1		2		1	9
Cellulitis					1	4		3	1	2	3		14
Stasis Dermatitis												1	1
Acne Vulgaris										1			1
Hordeolum		1											1
Carbuncle					1								1
Musculo-Skeletal Disorders:													
Rheumatoid Arthritis					1				1				2
Torticollis						1							1
Osteomyelitis						1							1
Synovitis							2	1			1		4
Bursitis								1					1
Gout									1				1
Sequelae (old hip injury)						1							1
Respiratory Diseases:													
Tuberculosis	1				1	1	2						5
Lobar Pneumonia	1	1	3	1	1	11	4	6	1	4	7	3	43
Upper Respiratory Infection (coryza, rhinitist	4	12	4	10	14	20	19	27	11	17	25	26	189
Bronchitis		3	3	2	6	13	7	3	7	2	6	4	56
Broncho-Pneumonia			1			1		1	2			1	6
Bronchial Asthma		2			2				1	1			6
Pneumonitis			1		1	3	1		1	2	2	1	12
Emphysema						1		1					2
Pleurisy						1							1
Pleuritis									1				1
Miscellaneous:													
Acute Ethylism	1								1				2
Periapical Abscess				1		1	1	8	2	1		1	15
Hemorrhage (post dental extraction)							1						1
Sequelae, Post Head Injury								1					1
Acute Inflammatory Reaction ? etiology					1					1			2
Chest Pain ? Etiology		1								1	1		3
Abdominal Pain ? etiology				1			2					1	4
Urticaria ? etiology						1							1
Injuries:													
On Job	3	7	7	9	20	34	24	39	45	36	49	25	298
Off Job	1		1	1			3	2		2	11	1	22

	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Total
Totals	24	38	30	28	84	150	120	169	118	123	144	105	1133

Prepared by:

Mr. Marco Maio, R.N.,
Manager, A.W.H.

Claims Submitted:

MW	66
PRC	693
BWI	1
NC	75
A/C	298
Total	1133

Outpatient Visits:

Dec.	62
Jan.	86
Feb.	63
Mar.	92
Apr.	556
May	857
June	667
July	732
Aug.	629
Sept.	611
Oct.	398
Nov.	285
	5038

Referrals to other Hospitals:

Total Treated	79
Admitted	23
Released	56

Medical Repatriations:

PRC	91
MW	10
NC	3
	104

Emotional Disorders	30
Seizure Disorders:	25
Dermatitis:	9
? T.B.:	6
Asthma:	4
Duodenal Ulcer:	4
Hypertension:	3
Diabetes Mellitus:	2
Bronchiectasis:	2
Previous Cardiac Surgery:	1
Hemorrhoids:	1
Varicosities:	1
Cellulitis:	1
Leg Ulcer:	1
Rheumatoid Arthritis:	1
Chest Pain, ? Etiology:	1
Esophageal Stenosis:	1
Alcohol Addiction:	1
Attempted Suicide:	1
Inguinal Hernia:	1
Sequelae, Old Head Injury:	1
Emphysema:	1
Post-Operative Infection:	1
Metastatic Cancer:	1
Splenomegaly:	1
Anemia:	1
Allergic Reaction:	1
Tissue Mass. ? Etiology:	1
	104

Prepared Statement of Ernest B. Howard, M.D., Executive Vice President, American Medical Association

On behalf of the American Medical Association, I would like to take this opportunity to submit Medicine's support of S. 2660 now pending before your Subcommittee. It is our understanding that this bill would extend for five years the present Migrant Health Service Act. The legislation also authorizes special projects to improve health services and health conditions for these agricultural workers, and specifically authorizes the training of allied health professions personnel to provide services in the family health service clinics.

In past Congresses, during consideration of similar bills, the American Medical Association has testified in support of an extension of the program of health services to migratory workers. However, on the occasion of the last extension of this program we suggested that the program be extended with a view toward phasing it into the Title 19 medical assistance programs. While we continue in this recommendation, there remains a clear need for health service clinics for migrant workers and their families, and for the expansion of the program to include other agricultural workers. These people are usually members of a low-income group with a demonstrated difficulty in obtaining preventive and curative health care. Because of cultural differences, language barriers, minimal education, mobility, poverty, and lack of a meaningful residency status, they have not been effectively integrated into the existing and more usual health care systems. Compared with the rest of the population, they have the highest rates of infant and maternal mortality, nutritional deficiencies, communicable diseases, and accidents and their living conditions are generally characterized by poor housing and inadequate environmental sanitation.

It is apparent that this population group requires, and must be given, special attention.

On the basis of the facts evident among our agricultural workers, we would urge that the Subcommittee extend the present Migrant Health Service Act program and to expand it to include non-migrant seasonal agricultural workers and their families. We would also favor other constructive and beneficial efforts, including education in the use of existing community health resources, so as to make a substantial improvement in the health and living conditions of these workers.

We appreciate the opportunity of submitting our views on this legislation and request that our letter be included in the record of your hearings.

Prepared Statement of the American Federation of Labor and Congress of Industrial Organizations

The Migratory Workers provisions of S. 2660 would extend the Migrant Health Program to 1975.

The average annual income of the migrant farmworkers in 1967 was $1,500. While the average annual expenditure for personal health care is more than $250 per person for all Americans, the figure is only $12 per year for the migrant, including $7.20 in Federal funds and $4.80 from other sources.

During the 1968 fiscal year, of the one million men, women and children who travel the migrant stream about 310,000 have access to Migrant Health Act project services.

By August 1, 1967, 118 public or private nonprofit community organizations were using migrant health grants to help them provide medical, nursing, hospital, health education and sanitation services to their seasonal migrants; but, three-fifths of the counties identified as migrant home-base or work areas are still untouched and service coverage remains weak in many of the areas where projects are now receiving grant assistance.

One or more migrant health projects operate in 36 states and Puerto Rico. Each project serves migrants in from one to 20 counties. Community-based projects offer personal health care to migrants in about 317 of the 901 counties thus far identified as migrant work or home-base areas. They offer sanitation services in most of these and in an additional 139 counties. About 40 home-base counties, reporting an estimated outmigration of 200,000 persons, are included in migrant health project areas in southern Florida, Texas, New Mexico, Arizona, southern California and the bootheel of Missouri. Continuity of care becomes more possible as project services are provided at strategic points along major migration routes. Personal health records carried by the migrants facilitate continuity and help to avoid duplication or gaps in services.

For continuity of care and protection, migrants need access to health services in every county where they live and work temporarily. Because geographic coverage by project services is still far from complete, a total of 690,000 migrants had no access to personal health care provided through projects in 1969. The remainder had ready access to personal health services for only part of the year.

Only one out of three counties with migrants offered grant-assisted personal health care geared to the special needs of migrants during 1966. Only six out of ten counties offered protection of their living and working environment through sanitation services with grant assistance. Lack of continuity of health care will remain a problem as long as many communities have no place to which a migrant can turn and expect to find needed health care. Recently, in one of the wealthiest states in the nation, a migrant with an emergency illness was refused care by 4 hospitals because he could not assure payment of the bill. At the fifth hospital where he obtained attention, doctors said that the patient would have died if he had had to shop around for hospital treatment for another two hours.

Migrant farm workers are not commuters. They travel so far from their homes that they must establish a temporary residence in one or more other locations during each crop season. On the average, the people live and work in two or three locations annually. They may move several times from farm to farm or camp to camp at each location. At each of his temporary homes the migrant needs access to health services and a safe home and work environment; but his home base and work communities are typically rural, isolated, lacking in both economic resources and health resources. As a result the typical migrant home is small, overcrowded, and of substandard construction. It often lacks facilities for food storage and preparation. It often lacks adequate and safe water supply for drinking, dishwashing, bathing, and laundry. The area too often lacks adequate sewage and waste disposal facilities which attracts insects and rodents. There are no recreational areas or facilities. The typical places where they work are exposed to heat, cold, wind, dust, chemicals and mechanical hazards. On some farms there are no facilities at all.

The migrant's road to health care is beset with obstacles—on the side of the migrant is poverty, lack of health knowledge, isolation, fear of non-acceptance by the community. On the side of the community are legal restrictions against serving nonresidents, legal exclusion from protective legislation, health planning priorities that exclude migrants, inadequate health manpower, inadequate financial resources, problems of serving a mobile group and resistance to minority groups. Many of the communities where migrants live and work temporarily are themselves considered poverty areas.

Little wonder then that the accident mortality rate for migrants from 1964 to 1966 was 40 percent higher than the U.S. rate. It was 6 percent greater than the U.S. rate 30 years ago. Migrants' mortality from tuberculosis and other infectious diseases from 1964 to 1966 was nearly two times the national rate, approximately the national average of over a decade ago. Their mortality from influenza and pneumonia was about 20 percent higher than the national rate.

Of the more than one million migrants, including workers and their dependents, 690,000 still live and work outside the areas served by existing migrant health projects. By conservative estimates, this group includes:

1. Over 6,500 persons with diabetes who are without adequate medical care.

2. Over 5,000 migrants with tuberculosis who are traveling and working with their disease undetected and untreated.

3. Over 3,000 children under the age of 18 who have suffered cardiac damage as a result of rheumatic fever. These children are not likely to receive treatment for prevention of reinfection and further cardiac damage. Such treatment is ordinarily available to most nonmigrant children in their communities.

4. Approximately 9,800 children who have untreated iron deficiency anemia. This increases their susceptibility for childhood infection and interferes with their normal growth and development.

5. Over 250 infants who will die in the first year of life as a result of congenital malformation or disease. Early, adequate medical care will not be available for these infants. Seven and one-half times as many migrant infants are born outside of the hospital.

6. Over 16,000 expectant mothers who will find it difficult to obtain prenatal care. Infant and maternal mortality rates can be expected to be significantly higher under such conditions.

7. Between 20,000 to 30,000 individuals who have enteric parasitic infestations—resulting in most cases from poor sanitation. Such a problem is almost nonexistent in the general public.

Before the passage of the Migrant Health Care Act in 1962 the migrant farmworker had virtually no medical care available to him and to his family. Only in grave emergencies did he get care, and even then he was frequently denied the needed medical services. Much progress has been made since 1962 but there is still a long way to go before the migrant farmworker and his family will have available even the barest minimum of medical services.

Certain facts are highlighted which show progress is being made, but there is also evidence that the progress is too slow, and only a small segment of the migrant population is the beneficiary of the migrant health program.

1. The migrant health program provides prenatal and postnatal care, obstetrics service, immunization, examinations, and treatment for ordinary ailments. Of these services only about 120,000 individuals out of the one million men, women, and children who make up the migrant stream get this care. Also, this care is not continuous as not all communities have migrant project services facilities and as the migrant moves from camp to camp and from state to state these services become episodic, periodic or nonexistent.

2. Continuity of health care services for all migrant workers and their families is of the utmost importance for a rational nation-wide health care program. The American people today feel that health care services are a right. This concept should certainly encompass the men, women, and children who work in this country's fields and who make it possible for our people to be the best fed nation in the world.

There are still many deficiencies in the present migratory health program. While it is imperative that these workers and their dependents receive health care services these services are but one side of the coin. Good health is not primarily a matter of doctors, hospitals and drugs. That, we would submit, is good sickness care. Good health is primarily a matter of good housing, of proper nutrition, of adequate clothing, a safe water supply for drinking and good waste disposal facilities. Because the migrant farmworkers and his dependents lack these basic needs he will require a much higher level of health care services than most American families.

MRS. HUBERT WYCKOFF,
Watsonville, Calif., October 30, 1969.

DEAR SENATOR YARBOROUGH: As a former member of the Public Health Service Program Review Committee in Migrant Health and as a lifetime worker in the field of rural health problems, I want to let you know how pleased I am with the five year extension of the Migrant Health Service proposed in S. 2660.

With all due respect to the present efforts being made under P.L. 89–749 it will be a long time before this transient and low-income group of workers will be accepted and absorbed into the present system of medical care and environmental health protection.

I share the American Public Health Association position that the seasonal agricultural worker should be included in the service and that additional funds should be provided for this purpose. The State and Territorial Health Officers testimony by Dr. Peavy of Texas shared this view.

Since 1961 California has had health legislation covering both seasonal and migratory agricultural workers. It has proved a useful tool to supplement the Federal program in building health resources in small rural communities where it is hard to differentiate between migrant and non-migrant rural poor, nearly all of whom engage in seasonal farm work.

Representatives of many organizations interested in migrant health met recently to study the proposed national legislation and you should soon be hearing from them individually. There was a consensus that it would be most desirable to include the service to seasonal farm workers as provided in H.R. 13432 with an authorization of $25 million for the first year and increasing by increments of $15 million each year thereafter.

We are all very pleased with your interest and support for a health service to our migratory agricultural workers and hopefully next to all seasonal farm workers.

With best wishes, I am
Sincerely,

FLORENCE R. WYCKOFF.

UNIVERSITY EXTENSION,
THE UNIVERSITY OF WISCONSIN,
Madison, Wis., October 20, 1969.

Hon. RALPH W. YARBOROUGH,
Chairman, Senate Labor and Public Welfare Committee, Subcommittee on Health, New Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: The Wisconsin Governor's Committee on Migratory Labor would like to go on record in strong support of Bill S2660, introduced by Senator Yarborough, extending the Migrant Health Act for five years with increased appropriations each year.

In Wisconsin, ever since the Migrant Health Act was originally passed, we have taken advantage of the funds available for the ten to twelve thousand migrants who come to our state each summer. We have three clinics in operation, none of them large. We could use several more.

In addition to the work of doctors from communities close to the clinics, the University of Wisconsin Medical School—both faculty and students—has made its services available to the clinics. With this kind of cooperation we are indeed making good use of present funds and can use to even greater advantage any increased appropriations.

Sincerely yours,

(Mrs.) HELEN BRUNER,
Secretary, Wisconsin Governor's Committee on Migratory Labor.

PREPARED STATEMENT OF FAUSTINA SOLIS, PROJECT DIRECTOR, FARM WORKERS HEALTH SERVICE, CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

Mr. Chairman and Members of the Committee:

It is a distinct pleasure and a welcomed opportunity to appear before you concerning proposed legislation to extend the Migrant Health Act due to expire at the termination of the current fiscal year, June 1970. I am here to lend strong support to the extension of this act since my work makes me gravely aware of the serious implications which the discontinuance of this legislation would mean to the million and more migrant workers and their families in this country. Throughout the nation, state and local agencies receiving migrant health grants can document undoubtedly the breadth of health benefits that have been derived by migrants through the provision of personal and environmental health services. In addition, the existence of migrant health projects in various states has sparked the development of social and educational programs badly needed. The more intensively services are provided the more acutely aware we become of the layers of unmet needs that have remained invisible for so long. Unfortunately, the plight of the migrant is also mirrored in the resident rural poor whose needs and deprivations can be as harrowing as those of the migratory populations.

Though strides have been made in improving some of the living and working conditions of the migratory population we cannot disregard the fact that frequently they still reside in dilapidated and sub-standard dwellings, or in the absence of shelter, huddle in the orchards, riverbanks or makeshift shelters. They may be living in areas without running water or with unsafe water supply systems, under conditions that breed disease and life hazards. Their type of employment rates high in occupational disease and injuries in California. Their health status though somewhat improved continues to reflect untreated chronic diseases, malnutrition, absence of adequate prenatal care. Personal health care consists primarily of medical care for acute conditions and preventive services when these are available and accessible to them. Migrants tolerate gross dental problems because these services are generally beyond their economic means and even with migrant health funds, only emergency dental care (usually extractions) can be offered as a result of limited funding. Continuity of medical care cannot be assured since hospitalization for illness or electric surgery is not available. The migrants' uncertain mobile patterns, his social, economic, and geographic isolation constitute major detriments to his attainment of crucial health services.

In California, the program of health services for migratory workers and their dependents has progressed at various levels.

The special unit of Farm Workers Health Service in the California Department of Public Health evolved initially as a result of action on the part of state legislature in 1961 to provide specific health appropriations through the State

Health Department to provide health services for the seasonal agricultural worker and his family. Pilot projects were initiated to offer personal health care, both preventive and curative, at times and in locations which would make these services accessible and available to this population. Enactment of federal legislation in 1963 made it possible to extend the original six pilot projects to the current 22 seasonal and year-round operations.

California is comprised of 58 counties of which 42 can be classified as rural agricultural counties. Approximately 200,000 migrant seasonal workers work throughout the state during the peak harvest months. (See attachments 1 and 2).

All of the California migrant projects include personal health care, and 13 incorporate an environmental health component. Projects are funded through the following resources: Federal migrant health funds provide $1,500,000 in grants, the State provides $100,000 for local projects. Local projects supplement about 50% of services to the migrants in their area as their local contribution.

Though these amounts may appear to be significant in proportion to other states, the fact remains that in California less than 15% of the estimated population in need of medical and dental services is reached through existing projects. In 1967–68, 48,000 visits were made to clinics. These visits represent about 20,000 patients. We anticipate a slight increase in the 1968–69 figures which are now being tabulated. However, in the past the clinic data reflected only primary conditions, that is, the symptom or diagnosis that was made at the time of the visit. This data does not give a true and accurate health profile of the multiple conditions of illness that patients may have.

We estimate that in the total state, at least 50% of the migrant population receives some form of preventive services. Limited funding has imposed restrictions in the expansion of programs as well as in the initiation of projects where need exists. Health care is costly, facilities are inadequate, and a paucity of health manpower in rural areas predominate the difficulties of achieving adequate personal health care.

PERSONAL HEALTH CARE PROGRAM

Migrant health funds in California have made it possible to increase efforts in early detection and treatment of disease through the employment of additional paramedical and auxiliary personnel. There are approximately 30 part-time and full-time community health workers assisting in health clinics, working with families in farm labor centers, and in general community. They are engaged in case-finding, social assistance, home visiting, educational activities and providing interpreting services. Sanitation aides (4) are employed for sanitation activities centered primarily in the working environment. (See attachment 3.)

In the area of personal health care, we have been fortunate in having invaluable cooperation from local county medical societies in the staffing of evening clinics. Four local county medical societies administer and operate migrant health clinics. All medical care clinics include the full complement of preventive services available to the general population, i.e., public health nursing services, preventive health measures—immunization clinics, well-baby clinics, prenatal and post-natal care, family planning services, tuberculosis screening, other communicable disease control, and health education. Clinic sessions and clinic attendance have increased annually. Preventive services are now frequently requested by patients themselves. Seventy-five percent of referrals to clinics are through self-referrals or family or friends. Special efforts are made by local projects to enlarge the scope of their services to provide improved quality of services. Many are now providing laboratory screening at the clinic site, particularly in those clinics that operate only once or twice weekly.

Health education as an activity includes not only the participation of the health workers in assisting migrant families to understand and care for their health problems but includes helping the professional health worker understand the special health practices and values of the families. All projects have as part of their staffing, billingual workers. The state staff itself includes four Spanish speaking professionals and one secretary. Through the efforts of the state bilingual material is prepared and translated or perhaps developed in Spanish itself.

ENVIRONMENTAL HEALTH

As important as personal health care measures are, our projects feels strongly that sufficient emphasis has yet to be increased in the areas of environmental health and occupational health.

The Farm Workers Health Service goal in environmental health is the development of effective local health department programs which will insure clean, safe, healthful environment for the seasonal and migrant farm workers and their families.

There are an estimated 4,500 farm labor camps in the state, some 1,750 with capacity for 125,000 persons in 13 local jurisdictions who receive support for a sanitation component in this migrant health project. Although many camps, particularly those constructed under the California Migrant Master Plan are adequate, others have numerous environmental deficiencies including unsatisfactory water supply, sewage disposal, garbage disposal and housing.

Although progress is being made in overcoming deficiencies such as increasing by 15% the number of camps with satisfactory water systems in 1967–1968 as compared to 1966–1967, much remains to be done before our objective of 90% of all camps in compliance is reached. (See attachment 7).

For 1968–1969—approximately $143,000 in migrant health act funds were budgeted in support of a sanitation component in 13 projects. Slightly more than 16 sanitarians, assistant sanitarian, and sanitation aide positions were supported (mainly salary and travel).

It is to be noted that here are essenially the same number of camps in 12 project counties as in 24 non-project counties yet surveillance activity in the non-project counties is considerably less:

Project counties: labor camps, 1,712; inspections, 4,121.

Non-project counties: labor camps, 4,121; inspections, 1,555.

The same can be said for field sanitation activity. Project counties contain about 45% of California's farms and irrigated areas. Almost 83% of total man hours spent in field crop sanitation activity and 75% of all inspections were provided by project county staffs. It is reasonable to assume that without fund support most local programs would provide only the same limited amount of service as non-project counties now provide.

THE FUTURE FOR MIGRANT HEALTH SERVICES

What are the alternatives to the continuation of migrant health services—should there be no extension of the migrant health act?

A recommendation that has been made for at least the past two years has been to incorporate migrant health services in the implementation of PL 89–749, The Comprehensive Health Planning legislation. I suggest that we look at the implementation progress of this legislation in the states and in the regions. What kinds of programs other than special and specific planning or demonstration programs are really in full swing? In fact, are the Council bodies organized and have the community needs been assessed realistically? Who is or will be the spokesman for the rural poor, much less the migrant in those Councils? Is the migrant who constitutes a minor percentage of the population going to be afforded priority consideration? Maybe I just tend to be pessimistic but progress thus far does not seem to insure comprehensive care for the migrant for some years to come. His lack of voting power, his mobility, his social and economic isolation plus his being non-vocal automatically reduces his competitive power for services.

Let us then consider another suggested alternative, Title XIX. Title XIX is a vendor payment system, it is not a health care system. It does not provide resources for care, it pays only for care provided, if that happens to be available. It is a program that attempts to do away with segregated care of the poor or medically indigent, allowing the patient his choice of physician but in the end the physician has his choice of whether he can accept another patient. In areas where there is shortage and maldistribution of physician manpower health care does not become that readily available. In addition, the seasonal employment and unemployment status causes a constant turmoil in procedures to establish certifiability of a family and only when that family can be linked into a welfare category. In recent months due to alterations in the reimbursement to county hospitals, under Title XIX formula for example, outpatient care in most county hospitals in rural California have effected a drastic increase in rates per outpatient visit which currently range from $7.00–$20.00 per visit. The outpatient clinics have always been used by the medically indigent when their resources were limited or care was needed on emergency basis. Even though the patient may undergo a means test to determine his liability for payment, he would rather not use the service than be plagued by bills that he cannot pay and feels obliged to pay.

Supportive services in the form of preventive services and follow-up care are not inherent nor assured as a part of health care in Title XIX as practiced.

Consideration has also been given periodically to pre-paid health insurance for this population. Attempts thus far have been unsuccessful due to the problem of inter-state mobility, undetermined labor itineraries, seasonal employment, and the undetermined actuarial costs to implement such a program.

All of these alternatives are not without merit but in the present state of health care—we foresee the need for continuation of special appropriations for migrant health beyond the next two years.

Attachment #1

CALIFORNIA AGRICULTURAL MIGRANT PROFILE
-Selected Characteristics-

The Population

- Over 200,000 agricultural migrant workers and their families were on the move in California during 1968 working in 43 counties.
- About 80 percent of them were of Mexican origin, 17 percent Anglo, and the balance American Indian, Negro, and other.
- About 37 percent are Californians, 27 percent from Texas, 18 percent from Mexico, 6 percent from Arizona, and the balance from other states.
- 31 percent of the wives of farm laborers delivering live babies in California in 1965 had five or more children compared to 14 percent for all occupational groups.

Income

- Median annual wage for California farm workers in 1965 including non-farm earnings was $1,388. Annual family income reported for families residing in OEO farm labor centers in 1968 was $3,000.
- The 1967 average hourly wage rate for California farm workers was $1.62 compared to $1.33 for USA farm workers, the lowest of all industries; $1.73 for laundry and dry cleaning, the second lowest; and $4.09 for contract construction the highest.[b]

Employment Benefits

- Farm workers are specifically excluded from unemployment insurance programs.
- In 1965, the claim rate for farm workers in the California Disability Insurance Program was 45 per 1,000 insured workers, compared to 94 per 1,000 for the general population.[c]

Evidence indicates that non-health factors affect under-utilization.

[a]Unless otherwise indicated, the sources for all data originates from the California State Department of Public Health, Bureau of Maternal and Child Health or Farm Workers Health Service.

[b]Source: U. S. Department of Agriculture, Statistical Research Division, Farm Labor, January 10, 1968.

[c]Source: "Sickness Insurance and California Farm Workers," Philip Booth, May 1968, Vol. 31, No. 5, U.S. Department of Health, Education, and Welfare.

Housing

- 3,897 families were turned away from 23 OEO Farm Labor centers between April and October in 1968.
- Compared to the general population of California, the conditions of deterioration and dilapidation in housing are five times worse for the migrants.

Health

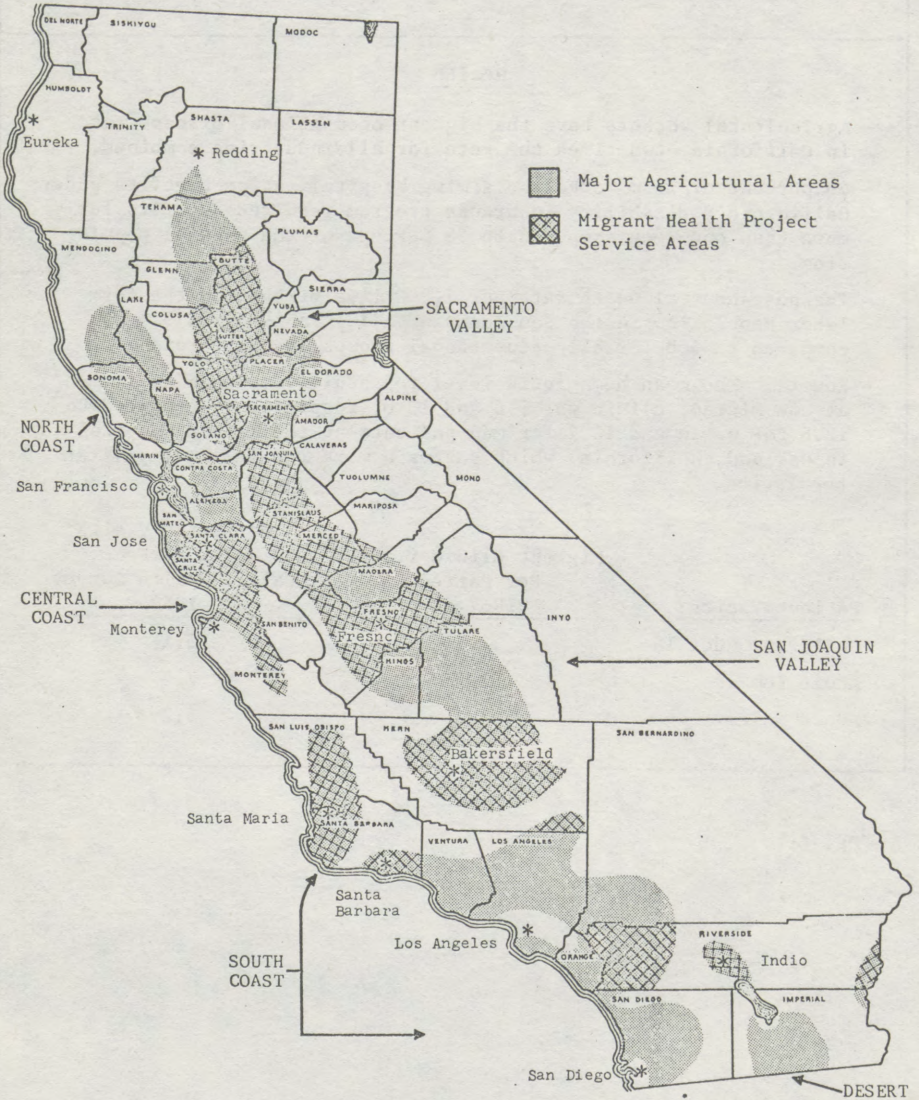
- Agricultural workers have the highest occupational disease rate in California, two times the rate for all industries combined.
- 48 percent of farm workers claiming hospitalization benefits under California's disability insurance program required benefits for more than one week compared to 38 percent of the general population.[d]
- The postneonatal death rate per 1,000 live births for the farm labor population in the San Joaquin Valley in 1965 was 9.1 as compared to 5.8 for all occupational groups in California.
- Anemia: The mean hemoglobin level for adult women and adult men at one migrant clinic was 9.6 and 13.0, respectively compared to 12.6 for women and 14.2 for men patients at the Kaiser Hospital in Oakland, California, which serves a more general metropolitan population.

Patient Visits:	Migrant Clinic Visits Per Patient 1967-68	Physician Visits Per Person Calif. Health Survey 1958
Children under 15	2.5	5.1
Adult Females	3.7	7.2
Adult Males	2.2	5.2

[d]Op. Cit.

Attachment #2

MAJOR CALIFORNIA AGRICULTURAL AREAS
AND MIGRANT HEALTH PROJECT SERVICE AREAS, 1968-1969



Attachment #3

California Migrant Health Projects
1968-1969

COUNTIES	YEAR BEGAN	FUNDING SOURCE	PERSONNEL	SERVICES
Butte	1962	USPHS	Clinic physician, nurse, interpreter, clerk	Seasonal medical clinic, fee-for-service
Colusa	1962	USPHS	Nurse, health aide, physician fee-for-service, sanitarian	Medical fee-for-service, seasonal nursing, sanitation
Fresno	1963	USPHS	Two sanitarians, 3 PHN's, LVN, clerk, physician	Year-round medical clinics, nursing, sanitation
Kern	1961	USPHS	Health educator coordinator, 3 part-time PHN's, sanitarian, 14 community health aides	Health education, public health nursing, sanitation
Kern County Medical Society	1967	USPHS	Physician, RN, clerks	Seasonal medical clinic
Merced	1961	USPHS	Physician, supervising nurse, 2 PHN's, sanitarian 2 clerks	Year-round clinics (2 areas), nursing, sanitation
Monterey	1961	USPHS	Supervising PHN, PHN $3\frac{1}{2}$ time, 2 sanitarians, clerk, bookkeeper, lab helper	Year-round medical and maternal clinics
Riverside	1966	USPHS	Physician, 2 PHN's, sanitarian, 4 community health aides, RN, 2 clerks, pharmacist	Year-round medical clinic, nursing, hospitalization, sanitation
San Benito	1967	USPHS	Sanitarian, health aide, clerk	Year-round nursing, sanitation
San Joaquin	1967	USPHS	Sanitarian, 2 sanitation aides, clerk	Year-round sanitation, dental
		Calif.		To supplement USPHS 1967-68
San Joaquin County Medical Society	1967	USPHS	Physician, PHN coordinator, RN, clerk, health aides, driver (mobile unit)	Camp clinics (6 mos.), year-round clinic, lab and x-ray
		Calif.		Fee-for-service, equipment mobile clinic, lab and x-ray, supplement USPHS program
San Luis Obispo	1964	USPHS	Physician, 2 nurses, health aide, clerk, sanitarian part-time, lab technician part-time	Year-round medical clinic, fee-for-service medical and dental, nursing, sanitation
Santa Barbara	1963	USPHS	Health educator, social worker, clerk, 4 part-time community health aides, sanitarian	Year-round health education services, social work, sanitation, medical and dental fee-for-service, medical services (collaboration with San Luis Obispo)
		Calif.	One part-time health aide	Year-round health education services, social work, sanitation, medical and dental fee-for-service, medical services (collaboration with San Luis Obispo)

California Migrant Projects (cont'd.)

COUNTIES	YEAR BEGAN	FUNDING SOURCE	PERSONNEL	SERVICES
Santa Clara County Medical Society	1966	USPHS	Physician, PHN coordinator, part-time social worker, RN, 2 clerks, administrator assistant, bookkeeper	Seasonal medical care clinic with fee-for-service
Santa Cruz	1962	USPHS	Physician, supervising PHN, PHN, sanitarian, nursing attendant	Year-round medical care clinic fee-for-service, public health nursing, sanitation
Solano	1967	Calif.	Physician, RN, PHN, 2 health aides	Medical clinic at Dixon Camp, dental fee-for-service
Stanislaus County Medical Society	1967	USPHS / Calif.	Supervising nurse, RN, secretary, community health aide	Nursing services, community health aide at camp site, year-round nursing services at camp sites with medical and dental fee-for-service
Sutter County General Hospital	1966	USPHS	Physician, 2 RN's, health aide, 2 clerks, pharmacist, lab technician, x-ray, technician	Medical care clinic, camp and hospital
Sutter-Yuba	1963	USPHS	Two PHN's, sanitarian, clerk	Public nursing, sanitation service
		Calif.	One PHN part-time to work at medical clinic, Sutter County General Hospital	
University of California Davis	1968	Calif.	Physician, LVN, aide, clerk	Medical clinic camp and hospital
Yolo	1961	USPHS	Two PHN's, sanitarian, 1 clerk	Year-round public health nursing, sanitation, fee-for-service medical and dental

Attachment #4

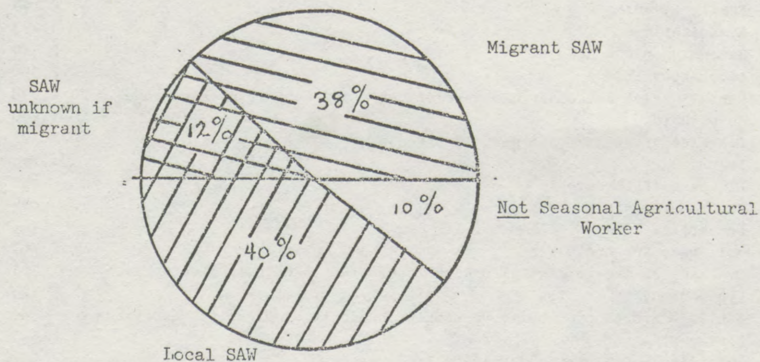
SPECIAL MEDICAL CONDITIONS IN RANK ORDER
CALIFORNIA MIGRANT HEALTH CLINIC OUTPATIENT - AND FEE-FOR-SERVICE VISITS
July 1, 1967 - June 30, 1968

		Number	Percent
1.	U.R.I. - Sore throat, common colds, pharyngitis, tonsillitis	5,877	10.9
2.	Prenatal Care	5,859	10.9
3.	Family Planning	5,194	9.7
4.	Immunizations	4,259	7.9
5.	Screening procedure	2,224	4.1
6.	Laboratory test	2,200	4.1
7.	Dental caries and other diseases of teeth and supporting structures	1,698	3.2
8.	No pathology	1,450	2.7
9.	Diseases of the ear and mastoid process[1]	1,123	2.1
10.	Injury	1,055	2.0
11.	Diseases of the eye[2]	851	1.6
12.	Gastroenteritis	844	1.6
13.	Dermatitis	791	1.5
14.	Well-baby and child care	767	1.4
15.	Diseases of female genital organs (other than menstrual disorders)	763	1.4
16.	Hypertrophy of tonsils	725	1.4
17.	L.R.I. - Bronchopneumonia, pneumonia, bronchitis, pleurisy, emphysema	580	1.1
18.	Post-partum care	543	1.0
19.	Infections of kidney and urinary tract	538	1.0
20.	Mental and emotional disorders	534	1.0
21.	Hypertension	530	1.0
22.	Surgical and medical after-care, follow-up	476	0.9
23.	Obesity	474	0.9
24.	Tuberculosis, case	456	0.8
25.	Allergic disorders (hay fever, asthma, urticaria)	451	0.8
26.	Tuberculosis, suspect	444	0.8
27.	Menstrual disorders	400	0.7
28.	Impetigo	398	0.7
29.	Diabetes	374	0.7
30.	Tuberculosis, contact	347	0.6
31.	Anemia	318	0.6
32.	Venereal diseases	280	0.5
33.	Oxyuriasis (pinworms)	251	0.5
	Total for Specific Medical Conditions*	43,074	80.2
	Total for All Other Conditions	9,213	17.5
	Condition not Reported	1,410	2.6
	GRAND TOTAL	53,697	100.0%

[1] 880 Otitis
[2] 519 Conjunctivitis
*Only diseases with an incidence of 0.5% or more are ranked here.

Attachment #5

Farm Worker Status[a] and Ethnic Background of
Patients in Clinic and Fee-for-Service Program
1967-68



Caucasian-Mexican	80.2%
Caucasian-Anglo	17.1%
All Others[b]	2.6%
	100.0%

Total number	17,540
Ethnic background - not reported	3,773
Total	21,313

[a]Number of patients excluded from consideration because Farm Worker Status was not reported = 1,166

[b]American Indian, Negro, East Indian and Oriental.

Attachment #6

COMPARISON OF CLINIC ATTENDANCE AND FEE-FOR-SERVICE STATISTICS
1966-67 / 1967-68

NAME OF PROJECT	PATIENTS (New Admissions & 1st Visit This Year)		INCREASE DECREASE		VISITS		INCREASE-DECREASE		AVERAGE NUMBER OF VISITS PER PATIENT		NUMBER OF SESSIONS		AVERAGE NUMBER OF PATIENTS PER SESSION	
	1966-67	1967-68	Number	Percent	1966-67	1967-68	Number	Percent	1966-67	1967-68	1966-67	1967-68	1966-67	1967-68
BUTTE CO.														
Gridley Camp Clinic	345	397	52	15.1	687	791	104	13.1	2.0	2.0	26	23	26.4	34.0
Gridley Fee-For-Service	na	67[1]	-	-	na	247	-	-	na	na	-	-	-	-
COLUSA CO.														
Fee-For-Service	na	119	-	-	na	131	-	-	na	1.1	-	-	-	-
CONTRA COSTA CO.														
Fee-For-Service	na	34	-	-	na	39[2]	-	-	-	1.1	-	-	-	-
FRESNO CO.														
Migrant Health Services	1,484	1,910	426	28.7	5,123	5,620	497	9.7	3.4	2.9	98	136	52.3	41.0
Firebaugh Night Clinic	758	927	169	22.3	3,777	3,961	184	4.9	5.0	4.3	100	101	37.8	40.0
Westside Night Clinic	462	610	148	24.3	1,750	1,875	125	7.1	3.8	3.1	48	49	36.4	38.3
Huron Night Clinic	380	636	256	67.4	1,621	1,739	118	7.3	4.3	2.7	46	53	35.2	32.8
KERN CO. MEDICAL SOCIETY														
Lamont Migrant Clinic[3]	-	636	-	-	-	1,351	-	-	-	2.1	-	45	-	30.0
MERCED CO.														
Planada Night Clinic	1,776	1,090	-686	-38.6	3,288	2,310	-978	-29.7	1.8	2.1	51[4]	50[4]	44.2	32.8
So. Dos Palos Night Clinic	1,632	1,182	-450	-27.6	3,424	2,535	-889	-26.0	2.1	2.1	51[4]	51[4]	37.6	31.9
Flash Peak Camp Clinics(OEO)	na	553	-	-	na	867	-	-	na	1.6	-	47	-	18.4
RIVERSIDE CO.														
Indio Out-Patient Clinic	933	984	51	5.5	2,008	2,339	331	16.5	2.2	2.4	224	238	9.0	10.0
Blythe Fee-For-Service	na	165	-	-	na	647	-	-	-	3.9	-	-	-	-
SANTA BARBARA														
Fee-For-Service	na	57	-	-	na	107	-	-	na	1.9	-	-	-	-
SAN LUIS OBISPO CO.														
Nipomo Migrant Health Cent.	381	906	525	137.8	721	2,663	1,942	269.3	1.9	2.9	30	89	24.0	33.0
Nipomo Fee-For-Service	na	130	-	-	na	262	-	-	na	2.0	-	-	-	-
SANTA CRUZ CO.														
Pajaro Family Care Clinic	542	741	199	26.8	1,157	1,462	305	26.4	2.1	2.0	59	65	19.6	22.5
MONTEREY CO.														
Family Care Clinic	450	526	76	16.9	918	1,027	109	11.9	2.0	1.6	63	62	14.6	16.6[5]
Gonzales Prenatal Clinic	na	134	-	-	na	611	-	-	na	3.6	na	50	na	12.0
SAN BERNARDINO CO.														
Fee-For-Service	na	45	-	-	na	153	-	-	-	3.4	-	-	-	-

Attachment #6

(cont'd) COMPARISON OF CLINIC ATTENDANCE AND FEE-FOR-SERVICE STATISTICS
1966-67 / 1967-68

NAME OF PROJECT	PATIENTS (New Admissions & 1st Visit This Year)		INCREASE-DECREASE		VISITS		INCREASE-DECREASE		AVERAGE NUMBER OF VISITS PER PATIENT		NUMBER OF SESSIONS		AVERAGE NUMBER OF PATIENTS PER SESSION	
	1966-67	1967-68	Number	Percent	1966-67	1967-68	Number	Percent	1966-67	1967-68	1967-68	1967-68	1966-67	1967-68
SANTA CLARA CO. MEDICAL SOC.														
So.County Migrant Clinic	1,106	2,011	905	81.8	1,729	3,399	1,670	96.6	1.6	1.7	68	67	25.4	50.7
SAN JOAQUIN CO. MED. SOCIETY[6]														
Labor Camps & Mobile Clini.	775	3,648	2,873	370.7	1,980	9,279	7,299	368.6	2.6	2.5	98	501	20.2	18.5
Fee-For-Service		na	-	-	-	na	-	-	-	na	-	-	-	-
SUTTER CO. HOSPITAL														
Hospital Migrant Clinic	1,831	1,856	25	1.4	4,391	4,781	390	8.9	2.4	2.6	138	154	31.9	31.0
Richland Housing Clinic[7)]	804	552	-252	-31.3	1,756	1,469	-287	-16.3	2.2	2.7	84	52	20.9	28.0
STANISLAUS CO.MED. SOCIETY[3]														
Offices of Health:														
Patterson	-	410	-	-	-	1,057	-	-	-	2.6	-	-	-	-
Westley	-	383	-	-	-	776	-	-	-	2.0	-	-	-	-
Empire	-	277	-	-	-	575	-	-	-	2.1	-	-	-	-
Med.& Dental Fee-For-Serv.	-	na	-	-	-	880	-	-	-	na	-	-	-	-
SOLANO CO. (OEO)														
Dixon Migrant Camp Clinic[3]	-	163	-	-	-	386	-	-	-	2.4	-	14	-	28.0
YOLO CO. (OEO)														
Madison Camp Clinic[3]	-	164	-	-	-	358	-	-	-	2.2	-	34	-	10.0
TOTAL	13,659	21,313[7]	7,654	56.0	34,330	53,697	19,367	56.4	2.5	2.5	1,184	1,881	29.0	26.0

ATTENDANCE STATISTICS - MEDICAL CLINICS ONLY	1966-67	1967-68	INCREASE-DECREASE Number	Percent
Number of Patients	13,659	19,626	5,967	43.7
Number of Patient-Visits	34,330	48,823	14,493	42.2
Number of Clinic Sessions	1,184	1,881	697	58.9
Average Number of Patients Per Session	29.0	26.0	-3	-10.3
Median Number of Patients Per Session,per Clinic	25.9	31.9	6.0	23.2

See footnotes next page

Footnotes

[1]Figure refers only to dental patients.

[2]Note from project: "Several of the bills indicated by their amount that several visits during a month were billed on a single invoice. However, since there was no ready manner to check these back at this time as to how many visits were entailed, such bills are counted as one service."

[3]Project not in operation 1966-67.

[4]Figures do not include "Immunization Only" and "PPD Only" sessions and patients.

[5]Average clinic attendance for Family Care Night is 18.9 and for Prenatal Night 6.7

[6]Figures for 1966-67 do not include Mobile Clinics. Figures for 1967-68 cover the period of April 15, 1967 - June 30, 1968.

[7]Clinic closed January 8, 1968.

[8]Figure includes 130 Nipomo Fee-For-Service patients who attended Nipomo Migrant Health Clinic prior to referral and are also included in that clinic's patient total.

Attachment #7

REVIEW OF THE SANITATION COMPONENT
IN CALIFORNIA MIGRANT HEALTH

--Comparisons and Observations*--

Comment or Observation	1966-67	1967-68	Significance
Number of migrant health projects with a sanitation component receiving federal grant assistance	13	13	
Number of sanitation positions (sanitarians, sanitation aides, clerks) supported by migrant health funds	14.75	16.75	+2
Number of man years of sanitation staff time in activity identified as relating to farm workers, including migrants.			
Project sanitarians and aides	11.28	12.77	
Other sanitarians	6.65	4.70	
Administration and supervision	3.51	4.14	
Total	21.44	21.61	
Number of man years of activity by type of service			
Inspection of labor camps	7.41	6.12	-17%
Inspection of other farm worker housing	4.87	5.09	+ 5%
Food crop sanitation inspections	6.10	5.30	-13%
Supervisory--administration--miscellaneous	3.06	5.10	+66%
Total	21.44	21.61	
Percent of migrant project sanitation activity supported by migrant health funds	53%	59%	
Approximate amount federal, state, and local funds used to support sanitation services relating to farm workers in project counties	$220,000	$250,000	
Number of project counties indicating more man hours spent in farm worker sanitation activities in 1967-68 as compared to 1966-67	*	8	

*Based on data submitted in Annual Progress Reports from local projects.

(cont'd.)

Review of the Sanitation Component (cont'd.)

Comment or Observation	1966-67	1967-68	Significance
Number of farm labor camps reported in 13 projects	2,509	1,742	-30%
Camps for single workers	61%	54%	-13%
Family camps	24%	28%	+70%
Camps with accommodations for both single persons and families	15%	18%	+20%
Total	100%	100%	
Approximate person capacity of farm labor camps in project counties	150,000	127,000	23,000
Number of labor camp inspections reported by project counties	3,450	4,164	+21%
Percentage of labor camps inspected at least once during report period	61%	91%	+50%
Number of project counties indicating all camps inspected at least once	3	8	
Percent of camps with water supply systems meeting acceptable public health standards	65%	80%	
Total number of inspections reported by project counties (camps, other farm housing, field toilets and handwashing facilities)	10,035	13,758	+37%
Number of housing inspections reported, other than camp housing	3,216	4,559	+42%
Number of inspections of field toilets and handwashing facilities (food crop sanitation)	3,369	5,035	+49%
Average number of inspections per sanitarian or aide position	546	833	+53%
Number of projects providing farm workers health service with requested statistical data such as:			
Total number of camps in jurisdiction	13	13	
Number of camps by type	10	13	
Capacity of camps	10	13	
Number camp inspections made	9	13	
Percent of camps inspected	8	13	
Number of housing inspections, other than camp	7	11	
Number of inspections--field toilet units	10	13	
Environmental status of camps	8	13	

Senator DOMINICK. The subcommittee stands adjourned.

(Whereupon, at 12:30 p.m. the subcommittee adjourned, subject to the call of the Chair.)

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